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ABSTRACT

This final report describes activities of the 3-year Project Lexington Multidisciplinary Training Program for Child Care Personnel at the University of Kentucky. The project goal was to train child care personnel in skills needed to facilitate the integration of children with disabilities into generic child care settings. The project worked with 11 child care programs providing multidisciplinary training to 103 child care personnel. The model involved 40 hours of training, including 22 hours of interactive classroom training, 6 hours of site visit/observation, 6 hours of supervised practicums, and 6 hours of center-based follow-up technical assistance. The interdisciplinary approach involved trainers with backgrounds in regular early childhood education, early childhood special education, physical therapy, occupational therapy, speech therapy, and severe and profound special education. Research/evaluation results indicated that training program participants increased positive attitudes toward serving children with severe disabilities and that collaborative relationships between day care and specialized service agencies were enhanced. An inservice training manual is appended and makes up most of this document. Titled "Project Lexington Inservice Training: Expanding Community Child Care Opportunities for Children with Special Needs," it includes an introduction and overview (including a competency list), guidelines and forms for a needs assessment, sample training formats, technical assistance formats and forms, and evaluation forms. The manual has 35 references and includes instructional material handouts. (DB)

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Project Lexington: Training Child Care Personnel To Serve Young Children With Disabilities In Integrated Settings (1989-1992)

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Final Report

Early Education Programs for Children With Disabilities
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Project Lexington: Training Child Care Personnel To Serve Young Children With Disabilities In Integrated Settings (1989-1992)

Project Overview

The Project Lexington Multidisciplinary Training Program for Child Care Personnel was a three year project, funded through the United States Office of Special Education Programs, Early Education Programs for Children With Disabilities Program (formerly Handicapped Children's Early Education Program). The project was administered through the Interdisciplinary Human Development Institute - University Affiliated Program, University of Kentucky.

The project goal was to train child care personnel in the skills needed to facilitate the integration of children with disabilities into generic child care settings located in Lexington- Fayette County, Kentucky. Project objectives focused on increasing the competencies of generic child care personnel to meet the needs of children with disabilities, particularly those with severe and multiple disabilities; increasing the number of children with disabilities, particularly those with severe and multiple disabilities, served in integrated, generic child care settings; increasing cooperation and collaboration between specialized and generic child care agencies; adding to the body of knowledge about multidisciplinary training models and their relationship to the integration of children with disabilities into generic child care settings; and disseminating information about the project design and results nationally and encouraging replication through existing or newly developed training resources.

The project worked with a total of eleven child care programs, providing multidisciplinary training to a total of 103 child care personnel. Several child care staff attended both an infant focused training session and a preschool training session. Personnel trained included: 9 child care program administrators; 27 lead teachers; 37 assistant teachers.; and 30 other (e.g. incomplete data sets) Additional information regarding staff trained is included in section V: Research Evaluation Findings.

The training model included a total of 40 hours of training, involving 22 hours of interactive classroom training, six hours of site visit/observation in community early intervention programs, six hours of supervised practicum in an integrated child care setting and six hours of center based follow-up technical assistance. A total of 9 training sessions were offered through the three year period, with two sessions canceled due to lack of participation/registration of child care staff.

Project Lexington Trainers were identified based on their disciplinary specialization and training experience. Each training team included a minimum of one regular early childhood educator and an early childhood specialist. During the course of the three year project, 12 core trainers were involved on multidisciplinary training teams; including 3 early childhood educators; 2 early childhood special educators, 2 physical therapists; 1 occupational therapist, 3 speech therapists, and one severe/and profound special education specialist. Each 40 hour training session also involved one three hour workshop on interdisciplinary service provision, including an interdisciplinary team panel; and one three hour workshop on working with parents, including a parent panel. Community-based observation included visits to five community early intervention programs. Participant practicums involved three specialized child care programs.

The project developed a number of components compiled into the Project Lexington Inservice Training and Technical Assistance Program manual. These components included: a) Introduction and Overview of the Project Lexington Inservice and Technical Assistance Training Program (including a five section competency framework); b) Needs Assessment, including the *Training and Technical Assistance Center Program Components Checklist; Early Childhood Staff Training Needs Assessment; Follow-up technical Assistance Needs Assessment; and Summary of Priority Training and Technical Assistance Needs Form.*; c) Project Lexington Inservice Training Formats; d) Project Lexington Inservice Program Technical Assistance Formats and Forms; d) Project Lexington Inservice Program Evaluation Forms; and e) Participant Training Manual: Content Summary.

Research/Evaluation results indicate that participants in the training program significantly increased positive attitudes regarding serving children with severe disabilities in generic child care centers. In addition, collaborative relationships were enhanced between day care and specialized community service agencies, which will allow for continuing technical assistance to day care centers when serving children with more complex disabilities. Funding policy governing health, education, and other intervention or supportive services appears to be a persistent inhibiting factor to day care centers developing their program capacity for providing coordinated transdisciplinary services to children with severe disabilities.

Project Lexington: Training Child Care Personnel To Serve Young Children With Disabilities In Integrated Settings (1989-1992)

Final Report

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Project Lexington: Training Child Care Personnel To Serve Young Children With Disabilities In Integrated Settings (1989-1992)

Final Report

Introduction

The following report and associated appended manual summarize the major accomplishments and activities of the Project Lexington Multidisciplinary Inservice Training Project (Grant Number **H024P9002**), for the duration of the project (October 1, 1989 - September 30, 1992).

I. Goals and Objectives of the Project

The project goal was to train child care personnel in the skills needed to facilitate the integration of children with disabilities, particularly children with severe disabilities, into generic child care settings located in Lexington- Fayette County, Kentucky.

The objectives of the project fall into five major areas, related to development and provision of inservice training for generic child care staff to serve children with disabilities. These include: 1) Increased Competency of Child Care Personnel, 2) Increased Number of Children With Disabilities Served in Generic Settings, 3) Increased Cooperation and Collaboration Between Specialized and Generic Agencies, 4) Increased Knowledge About Multidisciplinary Inservice Training Models Related to Integrated Child Care, 5) and Dissemination and Replication of the Inservice Model

Major Accomplishments: Highlights and Insights

Objective 1: To increase the competencies of generic child care personnel to meet the needs of children with disabilities, particularly those with severe and multiple disabilities.

1.1: To identify the specific training needs of identified personnel: The project developed a curriculum framework and associated needs assessment forms identifying core job responsibilities, knowledge, skills, and attitudes necessary for the provision of quality early-childhood services to children with disabilities in integrated early childhood settings. The framework includes five early childhood functions: 1) Provision of a Nurturing Child Care Environment; 2) Working Cooperatively With Parents; 3) Coordination of Assessment and Program Planing; 4) Planning and Implementing Curriculum; and 5) Ensuring Compliance With Federal and State Regulations and Guidelines. Needs Assessment forms include a Center Program Components Checklist, adapted from a NEC*TAS Early Intervention questionnaire, and an Inservice Training Needs Assessment, including skill objectives listed in the Project Lexington Curriculum Framework.

The Center Program Components Checklist was completed by day care center directors, while each staff member participating in the training completed the Inservice Training Needs Assessment. Participants also completed a follow-up Technical Assistance Needs Assessment following completion of the didactic portion of the training program. The Technical Assistance Needs Assessment includes the same skill objectives used in the Inservice Training Needs Assessment. Information from the needs assessment was summarized and provided to day care center directors and members of the training team using forms included in the project manual.

1.2: To adapt existing curricula to meet varying needs of targeted personnel: The Project Lexington Content Summary, synthesizes information from a variety of early childhood resources to provide a common baseline of information for trainers and participants. In addition, project funding allowed for acquisition of training materials for an early childhood resource library, available to participating ·project trainers and day care centers. Trainers for the project were selected based on prior experience and expertise training early childhood personnel. Trainers utilized the content summary, available resource materials, and their existing training strategies to develop training sessions to address participants priority training needs.

1.3: To deliver state-of-the-art multidisciplinary training, using participatory methodologies, including practicum opportunities: The training model is described in detail in Section III of this report.

1.4: To provide on-site follow-up consultation and technical assistance: Consultation and technical assistance was provided in two ways. First, the project director met with all day care center directors following training sessions to address the directors questions and plan for on-site technical assistance for their staff. Technical Assistance was provided in each center, depending on priorities of directors and staff. Project staff identified and contracted with experts in associated topic areas to provide on-site technical assistance. While some participants elected to have one-on-one technical assistance, most center directors and participants chose to have targeted technical assistance provided to a group of staff members. Thus, while training was provided to a smaller number of participants, targeted technical assistance in specific topic areas was provided for a broader number of center staff.

1.5: To evaluate the effectiveness of the training through on-site observations: While an observation form was developed by project staff, use of the form was limited by several factors. First, many project participants did not currently have a child with a disability in their classroom. Implementation of the observation, therefore, was limited to verbal descriptions of how the staff member would address the item if they did have a child with a disability in their classroom. In general, results of the observation inventory were in the direction of appropriate responses by trained staff. A second limiting factor was that graduate students conducting the observations changed, so that consistency of interview strategies was not maintained, limiting the reliability of results. A third factor was the design of the observation inventory. While adequate for an informal assessment of staff knowledge and skills, the inventory was not sensitive enough to measure specific, concrete skills of staff. In summary on-site observations generally indicated that staff had basic knowledge about how to develop inclusive opportunities for children with disabilities in their classrooms, but were not useful in determining skill acquisition.

Objective 2: To increase the number of children with disabilities particularly those with severe and multiple disabilities, served in integrated, generic child care settings

2.1: To negotiate an incentive program with each participating child care agency: To encourage center participation in the training program, financial incentives were included in the training package as described in Section III of this report. Center directors were given broad discretion in how they elected to use the money. Generally, directors elected to transfer money to staff as reimbursement for participating in the training program. Since day care staff usually do not participate in such intensive training, the financial incentive provided partial reimbursement for their personal time spent in advancing their work-related knowledge and skills. Several directors, used some of the money to purchase related materials.

2.2: To impact attitudes of child care providers about integrated services, through increased awareness of the benefits to all children: Attitudinal change was one of the major targets of this project. As indicated previously attitudes were included with knowledge and skill objectives within the Project Lexington Curriculum Framework. The Project Lexington Content Summary includes a strong emphasis on the concepts of respect for diversity and the basic universality of children's basic needs. As discussed in the research section of this report, pre and post attitude assessment suggests that attitudes were positively effected by the training.

2.3: To encourage changes in policies, procedures, accessibility, and acquisition of needed materials and equipment to increase enrollment of children with disabilities: A working assumption of the project staff is that children with disabilities are frequently not included in generic day care centers, simply because center staff do not know how to access the available community resources (e.g. training, technical assistance, specialized consultation) and knowledge about early intervention strategies needed to plan and implement inclusive day care experiences. Emphasis in the curriculum design weighted interdisciplinary and interagency coordination heavily in designing training and technical assistance sessions. It was not expected that day care staff should be special educators, or would become special educators as a result of the training. Rather, the emphasis of the training program is on child care staff knowing who the players are and how to access their expertise as needed when a child with disabilities enters their day care program.

While child care providers were very receptive to this approach, some real systemic barriers to interdisciplinary and interagency collaboration exist which impede rapid expansion of day care providers as collaborative players in early intervention. Funding mechanisms, not surprisingly, are a primary impediment to transdisciplinary service provision in day care settings. As an example, the Lexington Hearing and Speech Center has been very receptive to having speech therapists provide center based therapy and technical assistance to day care staff. Unfortunately, however, neither health or education funding sources in Kentucky will pay for therapy provided to children in their day care setting, unless the day care center is registered as an early education contracting agency. A similar interest in specialized service programs working with day care settings, along with parallel funding dilemmas, were expressed by several other local agencies. Thus, while the Project Lexington Training Program apparently increased day care center and special service agencies interest in collaboration, their intentions were thwarted by systems funding restrictions. Policy issues that were beyond the scope of this three year project.

2.4: To inform parents about the advantages and availability of generic child care for their children with disabilities: Specialized agencies serving children with disabilities were extremely conscientious in explaining Project Lexington training activities and referring families in need of day care to participating day care programs. In addition, one of the primary early intervention agencies in the area has expanded services to include a fully integrated preschool classroom. As is so often the case with quality child care, however, the demand for inclusive child care far outweighs the availability.

Objective 3: To increase cooperation and collaboration between specialized and generic child care agencies.

3.1: To establish a Project Advisory Committee including representatives of specialized and generic child care agencies: The project director strongly believes in an advisory process rather than a single advisory board. For this reason several advisory mechanisms were used. First an Advisory Board was established which met during the first phase of the project. The project director also attended the local preschool interagency planning council (PIPC), which acts as the coordinating agency for preschool specialized services in the area, and Co-Chaired the United Way Child Care Committee. In addition, the project director maintained consultation with the project trainers and participating child care center directors and staff, who proved to be the most valuable advisory resource for purposes of the training project.

3.2: To increase knowledge and skills related to teaming among agencies and families around the needs of individual children: As suggested previously, collaboration (or the art of developing working relationships), is the heart of the Project Lexington philosophy. Family-centered individualized program planning is a core component of the curriculum framework, as is interdisciplinary teaming and transdisciplinary program planning using an interagency program planning scheme. The project takes a family-centered approach, promoting family members as the primary decision makers on behalf of their child, training day care providers in consultation and program planning skills needed to achieve this objective.

3.3: To encourage development of policies and procedures which facilitate interagency cooperation and collaboration: As described in 2.3 above, we believe that the project was successful in encouraging development of center-based policies and procedures which facilitate interagency cooperation and collaboration, however, systemic issues of turf and funding impede the functional development of these relationships at the local level.

Objective 4: To add to the body of knowledge about multidisciplinary training models and their relationship to the integration of children with disabilities into generic child care settings.

4.1: To collect and analyze data on the effectiveness of the training: The research plan for Project Lexington included two primary research questions: 1) After receiving training will the child care providers change their attitudes about integrated services; 2) Will the knowledge, skills and possible attitude changes acquired result in policy, procedure, and recruiting changes in the generic child care agencies? Discussion of the research results are included in Section V, pages twelve through eighteen. Briefly, research results suggest that child care provider attitudes were somewhat supportive of integrated programs prior to the training and improved following training. Changes in policy, procedure, and recruitment varied according to the degree of center staff involvement, with centers whose directors and a large proportion of staff were trained showing the greatest degree of active change.

4.2: To collect and analyze data on the number of children/types of disabilities enrolled in generic child care programs as a result of the project: The research model included a Child Care Questionnaire, which includes questions relevant to this objective. Discussion of the research results are included in Section V, pages fifteen and sixteen. Decisive analysis of enrollment as a result of the project was complicated by changes in state policy and procedures relating to infant and toddler early intervention and preschool programs for children with disabilities. For example, as a result of the Kentucky Education Reform Act (KERA) of 1990, which included specifications for state regulations related to school districts contracting with child care centers, some of the centers participating in Project Lexington became contracting agencies for preschool disabilities services, while other centers were not able to do so due to contracting restrictions such as qualifications of child care staff or religious affiliation. Thus, large increases in numbers of children with disabilities in some centers, with moderate to reduced enrollment in other centers, is believed to be reflective of state policy amendments rather than participation in Project Lexington. It should be noted, however, that Directors of participating programs regularly cited the number of staff trained through the project in their negotiations for becoming contracting agencies. In addition, several Project Lexington participants were hired from child care centers by the public school to become preschool teachers in the new KERA "at-risk" preschool programs for low-income children and three-and four year old children with disabilities.

4.3: To compare effectiveness of training and increased enrollments of children with disabilities among the varying settings: See 4.2.

Objective 5: To nationally disseminate information about the project design and results, and to encourage replication through existing or newly developed training resources.

5.1: To publish a final project report and disseminate it to appropriate national agencies and individuals: Copies of this report are being distributed to the project officer, ERIC, and other agencies or individuals upon request.

5.2: To make presentations at the state, regional, and national levels to share results of the project : Formal presentations were made at two national conferences, with informal presentations (e.g. panel discussions, topical discussions, workshops, etc.) ongoing.

5.3: To make the model inservice curricula available to local, state, and national generic training resources: A copy of the final project manual was distributed to approximately 100 Kentucky early childhood agencies or programs, 20 national programs upon request, and to the ERIC Resource Library. Additional copies are continuing to be distributed upon request.

II. Conceptual Framework for the Project

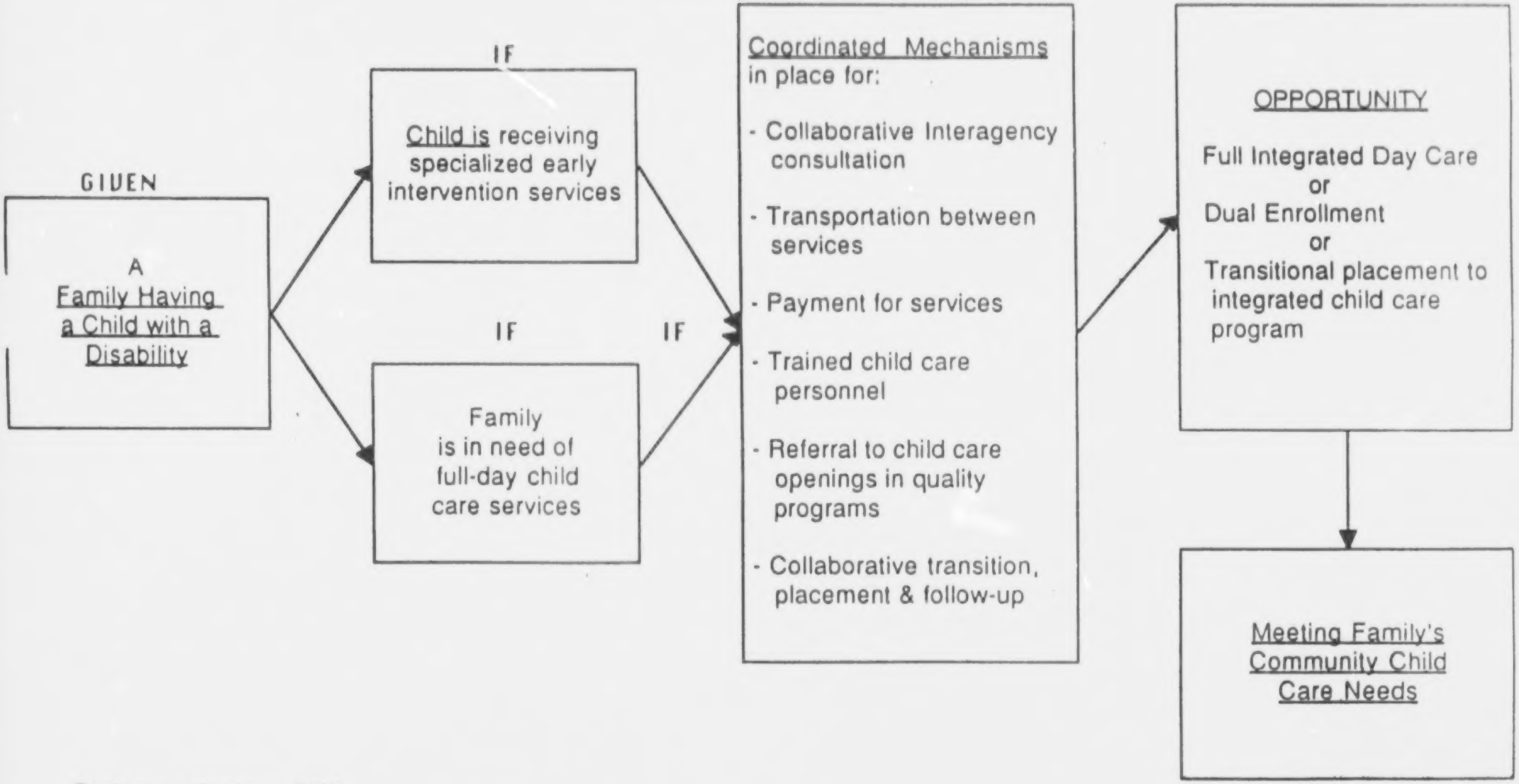
The Project Lexington Multidisciplinary Inservice Training Program Curriculum model was based on the following assumptions:

1. Parents of children with disabilities are likely to need day care for their children at least as much as parents of typical children.
2. Generic day care program staff are unlikely to have received in-depth training in serving children with disabilities in integrated child care settings.
3. In order to provide quality integrated day care programs, child care staff will need to receive related training, and develop cooperative and collaborative relationships with the special community agencies and direct service providers involved with developing and implementing the child's habilitation plan.
4. Day care workers should not be expected to be, or to become, special educators in order to be providers of day care/preschool programs, but rather be trained to participate as active members of early intervention or preschool service teams, communicate effectively with parents, and to translate therapeutic objectives into activities within an inclusive child care program.

A conceptual diagram illustrating a model for expanding opportunities for community day care services to families of children with disabilities follows.

EXPANDING OPPORTUNITIES

For Community Day Care Services to Families of Children with Disabilities



GIVEN

A
Family Having a Child with a Disability

IF

Child is receiving specialized early intervention services

IF

Family is in need of full-day child care services

IF

Coordinated Mechanisms in place for:

- Collaborative Interagency consultation
- Transportation between services
- Payment for services
- Trained child care personnel
- Referral to child care openings in quality programs
- Collaborative transition, placement & follow-up

OPPORTUNITY

Full Integrated Day Care
or
Dual Enrollment
or
Transitional placement to integrated child care program

Meeting Family's Community Child Care Needs

Project Lexington: 6/90

III. Description of the Training Model, Activities, and Participants

The Project Lexington Inservice Training Program was designed to provide early childhood professionals and paraprofessionals with the knowledge and skills needed for including children with disabilities in regular, generic, child care programs. The training focused on extending knowledge and skills in five general areas of early childhood job functions. These areas are:

I. Provision of a nurturing child care environment
II. Working cooperatively with Parents
III. Coordination of assessment and program planning
IV. Planning and implementing curriculum
V. Ensuring compliance with Federal and State regulations and guidelines

Training Program Objectives:

1. To train child care personnel in skills needed to facilitate the integration of children with disabilities into generic child care settings.

2. To tailor the inservice training program to:
    a) meet the needs of participating child care facilities,
    b) meet the needs of individual participants,
    c) recognize the current roles and levels of experience of the participants.

3. To provide an incentive program to participating child care facilities which:
    a) encourages involvement in training, and/or
    b) recognizes the fiscal cost of releasing staff for extended periods of time.

Participant Outcome:

The explicit participant outcome for the multidisciplinary inservice training program was:

> *As a result of participating in the Project Lexington Inservice Training Program, child care personnel will acquire attitudes and skills necessary to implement new roles as providers of services to both children with disabilities and typical children in integrated early childhood settings.*

Approach to Project Lexington Training:

Coordination of Training Program - Replication of the training model was anticipated, in stating the role and function of an inservice training and technical assistance program coordinator. The role of the inservice coordinator was carried out by the project director and graduate assistants during the project period. The roles and responsibilities of the coordinator as stated in the *Project Lexington Inservice Manual* are as follows:

> The provision of inservice training and technical assistance will be coordinated by an early childhood education specialist. The inservice coordinator is responsible for: a) identification and selection of early child care programs to participate in the inservice program; b) meeting with program directors and staff to conduct needs assessment, coordinate training and technical assistance activities, and provide consultation as

> needed; c) identifying, selecting, and training the core training team; d) meeting with trainers to provide a written summary of participant training needs and to plan the training agenda; e) evaluating the inservice training program; d) summarizing participant's technical assistance needs; e) planning the follow-up technical assistance schedule including, selection of technical assistance consultants and evaluation of technical assistance process; and f) maintaining contracting and financial reimbursement records for participating centers, trainers, and technical assistance consultants.

Needs Assessment - The need assessment component of the inservice training program is described below. Needs assessment information was collected and summarized by the project director, and distributed to the training team during half-day planning meetings. A summary of each center's training needs was given to center program directors. The needs assessment component states that:

> Inservice will begin with a center-based needs assessment to be completed by all levels of staff elected for training. Center directors will be asked to complete the Center Program Components Checklist. Each staff member who will be participating in the training program will complete the Inservice Training Needs Assessment. On completion of the classroom and practicum portion of the training programs, participants will complete the Follow-up Technical Assistance Needs Assessment.
>
> Following completion and review of the needs assessment, a training proposal will be drafted addressing each programs training needs. This proposal will outline the specific objectives, and schedule of the training designed to meet each center's identified training and technical assistance needs.

Inservice Program Development - As indicated, the design of the training sessions was guided by participant training needs. While the general framework of the training program remained the same, the structure was modified to address participants explicit training priorities. The procedure for inservice program development is described as follows:

> To assure adaptability of training and technical assistance to individual needs, the results of the needs assessment will be used by the inservice coordinator to guide the adaptation of existing inservice training curriculum, select appropriate training and technical assistance consultants, and grouping participants according to the level and type of training requested. Selection of core trainers shall include a minimum of an early childhood educator and an early childhood intervention specialist. Parent participation on the core team is preferred. In addition, arrangements shall be made to invite an interdisciplinary/ transdisciplinary intervention team, as well as a parent panel, to provide training related to multidisciplinary intervention practices and parent priorities, concerns and resources, respectively. Technical assistance consultants will be selected according to participant priorities and consultant expertise.

Pre-Training Self-Study - Project development of the Project Lexington Content Summary provided participants and trainers with a common conceptual foundation. The Content Summary is an eighty-five page referenced document, summarizing key information and concepts in each of five topical areas: 1) Trends in Integrated Early Childhood Special Education; 2) Designing an Inclusive Child Care Environment; 3) Working With Parents as Partners in Inclusive Child Care Settings; 4) Coordination of Assessment and Program Planning; and 5) Implementing Integrated Curriculum In Early Childhood Program. In addition to the Content Summary, the Participant Training Manuals included five corresponding appendix sections, where supplemental information was included dependent on participant and trainer priorities. A description of the Project Lexington Self-Study procedure follows:

To help assure a common starting place in terms of values, language/terminology, and understanding of the needs of children with disabilities, a copy of the Project Lexington Inservice Content Summary will be given to each participant before the classroom training begins. The inservice training team will use the Content Summary as a starting place for developing the training activities related to participant priorities.

Structure of Inservice Program - Following is the description of the Project Lexington inservice training and technical assistance structure, used throughout the project period:

> Classroom training will total twenty-two (22) hours, interspersed with twelve (12) hours of community-based practicum experience. The training will focus on methods for working with infants and children with disabilities in integrated early childhood settings. Classroom training will be provided by a core team of trainers and guest training consultants representing a variety of disciplines, to emphasize the value of a team approach to service provision. The training will be developed to include cooperative learning strategies.
>
> Practicum experiences will be designed to provide participants with increased knowledge about local early intervention resources, as well as provide opportunity for supervised experience within an integrated childhood program.
>
> Follow-up technical assistance will be developed to address priorities identified by the child care program director and individual participants.
>
> Again, the specific training and technical assistance agendas will be guided by the results of the center and participant needs assessments. The general inservice schedule involves:
>
> - six hours of classroom training on each of two Saturdays;.
> - four evening training sessions at 2.5 hours each;
> - twelve hours of community practicum, distributed in 1-2 hour sessions;
> - six hours of follow-up consultation/technical assistance at each child care center.
>
> In general the total training session extends over a six to eight week period. Adjustments to the inservice schedule may be made according to the needs of the child care programs participating in the training program.

Selection of Participants - Selection of participants for the inservice program remained the responsibility of center directors. A statement regarding selection of staff participants based on non-discriminatory criteria, was signed by all directors selecting staff for training. The instruction to center directors follows:

> In selecting personnel to participate in the Inservice Training, we ask that center directors identify a variety of staff members who have responsibilities for areas such as: policy and procedure development, working directly with children birth-2 and/or 3-5 years of age (i.e. teachers and associate teachers), and working with parents (i.e. parent coordinators). Center Directors are encouraged to participate in the training with their staff. Additional consideration may be given to staff involved with monitoring

children's health status, planning staff development activities, or other specialized functions important to child care service delivery within the center program.

Incentive Budget - Recognizing the cost to centers and participants of the intensive training program, the project included a training incentive, described below:

> An amount of not less than two hundred dollars ($200.00) per trainee is recommended as the incentive payment to child care programs for staff participation in the intensive inservice program. Examples of acceptable spending categories include: staff incentive, substitute teachers, purchase of adapted equipment, facility/playground modification, professional materials, or other expenditures directly related to the development of the center's integrated child care program.

Evaluation - Following is the description of the Project Lexington evaluation component:

> Project Lexington includes an evaluation component developed to assist our teams of participants and trainers to achieve the goal of promoting the skills needed to facilitate the integration of children with disabilities into each center's program. The procedures for evaluation include:
>
> a) Pre/post completion of the Early Childhood Program Profile by the child care center director;
> b) Completion of a pre/post knowledge and attitude scale by staff participants; and
> c) Completion of a child care program observation pre/post participation in the inservice program.

Project Lexington Curriculum Framework:

The project developed the Inservice Curriculum Framework, which identifies core job responsibilities, knowledge, and skills necessary for the provision of quality early-childhood services to children with developmental disabilities in integrated early childhood settings, including five areas of early childhood job functions:

I. Provision of a nurturing child care environment
II. Working cooperatively with Parents
III. Coordination of assessment and program planning
IV. Planning and implementing curriculum
V. Ensuring compliance with Federal and State regulations and guidelines

In addition to responsibilities, knowledge and skills, the attitudes that child-care staff hold about working with children having disabilities in an integrated child care setting are considered critical. Within each area of job responsibility the Curriculum Framework, therefore, includes a list of attitudes which should be incorporated in the design of the inservice training program.

The training and technical assistance needs assessments include each of the 29 basic skills listed in the curriculum framework. The framework includes additional knowledge and attitude competencies related to these skills. The curriculum framework should, therefore, be used by the inservice coordinator and training and technical assistance consultants as a guide for the inservice program development. As the inservice program is developed, related knowledge and attitude competencies should be included in planning the interactive training and technical assistance activities associated with the participants identified priority skill areas.

IV. Methodological Problems and Resolution

Numbers of centers/participants served. The original project proposal called for 23 Child Care Centers and 150 child care staff to be trained through the project activities. Actual number of centers participating was 11, with 103 project participants receiving the full 40 hours of training. The 11 centers included the Lexington-Fayette Community Action Head Start Program, however, with 35 staff trained in 9 different centers. An attempt was made to recruit a broad range of centers in years one and two through mailing descriptions of the project to child care programs listed in a local directory. In general this was not an effective method of recruiting additional centers. Of all centers participating, only two were a result of the mailing.

Training sessions were limited to a maximum of 15 participants to allow for interactive training (e.g. skill development, role playing, etc.). A total of 9 training sessions were provided, with 2 training sessions canceled due to insufficient registration. Both of the canceled sessions were in the early fall, when day care programs were just beginning their new program year.

Measuring Increase in Number of Children Served As noted in 2.3 of Section I, changes in state policy during the project period complicated tracking the increase in number of children served as a result of training. In 1990, the Kentucky general assembly passed a comprehensive education reform bill. Included in this was part-day preschool for four-year-old at-risk children. The State also made the decision to include the 3- and 4-year-old children with disabilities (PL-99-457) in these 4-year-old at-risk preschool programs. This turned out to be a double edged sword for Project Lexington program participants. Programs already serving 3-and 4-year-old children with a disability and at-risk children contracted with the public schools to provide the services they were already providing to more children. Thus, large increases in numbers in some programs. Other programs who could not contract with the public schools to provide services because they had a religious affiliation or did not serve at-risk children, and thus children that these programs may have recruited and served were enrolled in other programs in the public school or the community that had contracts with the public schools.

V. Research/Evaluation Findings

Research needs identified by the project included the need to: a) develop and evaluate a model to provide basic knowledge and skills to generic child care providers to improve the availability and quality of services provided to children with disabilities in generic child care programs; b) determine what role attitudes play in increasing the integration of children with disabilities into generic child care programs; and c) compare participant programs in terms of effectiveness of the training model and increased enrollment of children with disabilities, particularly those with severe or multiple disabilities, in generic child care settings.

The research model for Project Lexington used a variety of procedures to collect and analyze data concerning the training needs of the participants, current agency operation, post training evaluations, and follow-up observations. A Child Care Center Questionnaire was designed to collect specific, comprehensive, information about the program's current operation, including specific information about job descriptions, staff, qualifications, enrollment procedures and policies, recruitment, characteristics of children enrolled, classroom equipment, outdoor equipment, staff/child ratios, and staff training levels. This questionnaire was completed by Day Care Center Directors. A pre-post knowledge and attitudes questionnaire was completed by all project participants to attain data on knowledge and attitude change. Basic information from the research/evaluation component is reported below.

Attrition

Of the 84/103 child care providers that completed Project Lexington training for which data sets are available, 21 had left their child care positions by June of 1992. Six child care providers had moved out of the city, one had returned to school full-time, three were hired by the public school 3- & 4-year-old at-risk preschool program, one had returned to full-time homemaking, and the remaining ten child care providers had left their positions but current employment status was not available. Thus available data suggests that 25% of the participants that completed Project Lexington training were no longer employed at the center where they received the Project Lexington training.

This statistic in not surprising as the national turnover rate in child care settings is approximately 40%. Providers who left their positions for other early childhood jobs will be able to apply their knowledge in the new setting if administrative and philosophical views allow and encourage integration.

Program Description Summary

Of the eleven early childhood programs participating, two were private, non-profit; two were private, for-profit; one was publicly funded; one was a Head Start; four were church affiliated; one was college/university affiliated. One of the programs also served as a corporate child care program, but the corporation operated private, for-profit centers. (Further data is not reported for 1/11 centers due to incomplete data).

Centers that participated operated both part-time and full-time programs. The times of the programs ranged from 2 1/2 hours a day to 11 1/2 hours a day. The majority of the centers were open 52 weeks a year with a range in all participating centers of 32-52 weeks of operation.

The participating centers were licensed to serve from 95 - 269 children with the average number of children licensed being 176. The centers were also licensed to serve children between the ages of six weeks and 12 years-of-age. The numbers of children being served by the participating programs at the beginning and the end of Project Lexington are listed below:

Infants (6 weeks - 12 mo)	143	153
Toddlers (13 mo - 24 mo)	114	132
Preschool (3 - 5 years)	105	116
School Age (6 - 12 years)	29	27

Five of the programs provided transportation for children and all five providing transportation reported that the vehicles were handicapped accessible. However, of the vehicles that were handicapped accessible, not all had a wheelchair lift.

The teachers educational preparation in the participating programs was reported for 73 participants, and ranged from having a high school diploma or a GED to holding a masters degree. The largest number of teachers (27) had either an Associate of Arts degree or some college. Twenty teachers were reported in each category of holding a high school diploma or GED and a bachelors degree. Six teachers had some graduate work completed and eight held a masters degree.

The assistant teachers ranged in educational preparation from less than a high school diploma to completing some graduate work. The majority (37) of the assistant teachers fell in the category of having a high school diploma or a GED.

The administrators in the programs had educational credentials that ranged from an associate of arts degree or some college to a doctorate. The majority of administrators (9) held a bachelors degree.

PARTICIPANTS SUMMARY

Ninety-two percent of the participants were women. Forty-six percent of the participants were 26-35 years old, 22% were 19-25 years old, 22% were 36-45 years old, and 11% were between 15-18 years and over 46 years old. Fifty-five percent of the participants were white and 45% were black. Fifty-seven of the participants were married, 29% were single (never married), 8% were divorced and 6% were widowed.

Thirty percent of the participants had a high school diploma or a GED, 23% held a post secondary vocational degree, associates of arts degree or had some college courses but no degree. Twenty-three percent of the participants held bachelors degrees, with 13% reporting some graduate work completed, and 8% held a masters degree. The remaining 3% had either less than a high school diploma or a doctorate. The number of years of teaching experience the participants reported ranged from 1 to more than 10, with a mean of 5-6 years of teaching experience

Twenty-seven of the participants reported that they had received some training for mainstreaming young children in college courses. In addition participants had received training in alternative ways: 22 had attended community workshops/seminars, 84 had attended state or national conferences, 28 had read material on their own, 42 had received on the job training and 38 had attended at work workshop/seminars.

Seventy-five percent of the participants reported that they were assigned to a specific room and group of children. Forty-one percent reported that 16-20 children are assigned to their classroom, 40% had 15 or less children assigned to their classroom , and 19% had classrooms with more than 21 children assigned. Participants reported the following average teacher/child ratios in their classrooms: 39%, 1/4; 25%, 1/9or10; 10%, 1/6; 8% , 1/11 or >; 6%, 1/5; 6%, 1/7;and 6%, 1/8.

Ninety-one percent of the participants reported that they have and generally follow a daily schedule. And 85% reported that they have lesson plans, with age appropriate activities written and carried out every day.

Sixty-one percent of the child care providers reported an hourly salary of $6.01 or more per hour, while 27% reported a hourly wage of between $4.51 and $6.00, and 13% reported hourly wages as $4.25 an hour or less.

Thirty-six participants said that they had experience with mainstreaming children with a disability into their classroom before they participated in Project Lexington. Forty-three percent had 0-1 year of experience with mainstreaming, 32% had mainstreamed children for 2-3 years, 21% had experience mainstreaming children 4-5 years, and 4% had 7-8 years of experience. The number of participants that had experience mainstreaming children with the following disabilities were:

Developmental Delay	43
Mild Mental Retardation	27
Moderate Mental Retardation	13
Severe Mental Retardation	13
Orthopedic Handicap	23
Speech Impaired	35
Language/Communication Impaired	29
Visually Impaired & Blind	19
Hearing Impaired & deaf	22
Autistic or Autistic Like	16
Multiply Handicapped	19

Number of Children with Disabilities Served by Participating Child Care Programs

The reported number of children with disabilities served by the participating child care programs are listed in the tables below:

INFANTS

	Beginning of Project	End of Project	Change
Developmental Delay	7	9	+2
Mild Mental Retardation	1	1	0
Moderate Mental Retardation	4	4	0
Severe Mental Retardation	0	0	0
Orthopedic Handicap	0	0	0
Speech Impaired	0	0	0
Language/Communication Impaired	0	0	0
Visually Impaired & Blind	1	1	0
Hearing Impaired & Deaf	0	0	0
Autistic of Autistic Like	0	0	0
Multiply Handicapped	0	0	0

TODDLERS

	Beginning of Project	End of Project	Change
Developmental Delay	6	12	+6
Mild Mental Retardation	1	1	0
Moderate Mental Retardation	5	8	+3
Severe Mental Retardation	0	1	1
Orthopedic Handicap	2	2	0
Speech Impaired	4	9	+5
Language/Communication Impaired	2	2	0
Visually Impaired & Blind	0	0	0
Hearing Impaired & Deaf	0	0	0
Autistic of Autistic Like	0	2	+2
Multiply Handicapped	2	2	0

PRESCHOOL

	Beginning of Project	End of Project	Change
Developmental Delay	31	21	-10
Mild Mental Retardation	6	7	+1
Moderate Mental Retardation	6	11	+5
Severe Mental Retardation	3	6	+3
Orthopedic Handicap	5	5	0
Speech Impaired	16	46	+30
Language/Communication Impaired	73	84	+11
Visually Impaired & Blind	1	0	+1
Hearing Impaired & Deaf	0	0	0
Autistic of Autistic Like	3	4	+1
Multiply Handicapped	0	0	0

SCHOOL-AGE

	Beginning of Project	End of Project	Change
Developmental Delay	0	3	+3
Mild Mental Retardation	5	2	-3
Moderate Mental Retardation	1	0	-1
Severe Mental Retardation	0	0	0
Orthopedic Handicap	0	0	0
Speech Impaired	4	0	-4
Language/Communication Impaired	0	0	0
Visually Impaired & Blind	0	0	0
Hearing Impaired & Deaf	1	0	-1
Autistic of Autistic Like	0	0	0
Multiply Handicapped	0	0	0

It should be noted that while the numbers of children with disabilities increased in some area over the project period, the increases were in participating centers where we would have expected increases in numbers anyway. The participating programs who had an increase in numbers of serving children with disabilities, more specifically preschool children, were in some way tied to the Kentucky Education Reform Act (KERA) of 1990.

Participant's Attitude About Mainstreaming

Participants completed an attitude questionnaire adapted from the Larrivee and Cook Teacher Attitude Scale (Larrivee, B. & Cook,L. (1979). Mainstreaming: A study of the variables affecting teacher attitude. *The Journal of Special Education,* 13,3.) before the Project Lexington training (pre-test) and at the end of the Project Lexington training (pot-test). In addition participants were asked to complete the same attitude questionnaire six months after the training and 12 months after the training. To simultaneously analyze multiple measurements on each individual participating in Project Lexington, multivariate analysis or MANOVA was used. However, after initial analysis and exploration of the missing data, it was determined that MANOVA could not be used. Most missing data was due to the fact that people left their places of employment and could not be contacted for follow-up.

A paired T-test was used to assess the statistical significance of the difference between the pre- and post-test on the attitude questionnaire. Although change on all of the attitude questions was in the right direction, the change was significant in 18 of the 30 questions. The results of the paired t-tests are listed in the following table.

Teacher Attitude Change About Mainstreaming

	Pretest		Posttest		
Question	M	SD	M	SD	T-test
1	2.1571	.973	1.6143	.937	.000*
2	3.7429	.988	4.4571	.557	.000*
3	2.5694	1.161	3.3194	1.197	.000*
4	1.9306	.635	1.5833	.575	.000*
5	3.7429	.879	4.1429	.873	.000*
6	1.6714	.631	1.4571	.606	.001*
7	3.9859	.707	4.2676	.755	.002
8	2.8429	1.044	2.5571	1.030	.004
9	4.1250	.749	4.4167	.645	.000*
10	2.2254	1.045	1.5451	.905	.007
11	3.4444	.820	3.7222	1.051	.025
12	3.8000	.754	4.2714	.658	.000*
13	2.9861	.927	3.4861	.856	.000*
14	2.7606	.819	2.5634	.922	.004
15	4.1944	.547	4.4444	.625	.001*
16	3.7183	.831	3.1127	.994	.000*
17	3.7465	.691	3.8592	.850	.098
18	1.8732	.653	1.6620	.631	.005
19	3.1857	.889	3.7571	.875	.000*
20	3.1884	.713	3.4928	.933	.008
21	1.7917	.649	1.6528	.632	.029
22	3.0563	.893	3.2958	1.088	.023
23	4.0417	.659	4.2778	.510	.001*
24	3.3188	1.036	3.5507	.978	.031
25	3.8451	.730	4.1831	.593	.000*
26	2.3239	.968	2.1831	1.019	.174
27	2.7746	.929	3.3239	.982	.000*
28	1.6056	.492	1.3803	.489	.001*
29	3.7183	.865	1.3803	.489	.000*
30	1.8261	839	1.6667	.852	.069*

*p<.001

Of the 30 attitude items on the questionnaire, 18 were significantly different from the pre- to the post-test. The difference in attitude was also in the correct direction, when checking the means, except in one case. The participants were asked to respond to a statement using a five-point Likert scale with 1 being strongly agree; 2, agree; 3, undecided; 4 disagree; and 5 strongly disagree.

After the training sessions, participants felt that many of the things that they do with regular students in the classroom are appropriate for special-needs students (question 1). They reported that they agreed, moving toward strongly agree, that the challenge of being in a regular classroom would promote the academic growth of the special-needs child (question 4). In addition they agreed that mainstreaming offers mixed group interaction which will foster understanding and acceptance of differences (question 6). Also moving toward strongly agree, the participants reported that special-needs students should be given every opportunity to function in the regular classroom setting, where possible (question 28), and the presence of special needs students will promote acceptance of differences on the part of regular students (question 30).

The participants moved significantly toward strongly disagree when asked if the needs of handicapped students can best be served through special, separate classes (question 2). In response to the statement, "A special-needs classroom behavior generally requires more patience from the teacher than does the behavior of a normal child," participants reported on the pre-test that they were between agree and undecided (question 3). On the post-test they were firmly undecided about this statement, but moving in the direction of disagree. Possibly as they received the training and practicum experience they began to question if having a child with special-needs in the classroom really did require more patience from the teacher.

The participants moved toward strongly disagree between the pre- and post-test when asked, if the extra attention special-needs students require would be to the detriment of the other students (question 5). When asked if the behavior of special-needs students would set a bad example for the other students (question 9), participants responded that they disagreed with movement toward strongly disagree. When asked is most special-needs children do not make an adequate attempt to complete their assignments, participants responses moved toward disagree (question 12).

Participants moved from undecided to disagree when asked if integration of special-needs children will require significant changes in regular classroom procedures (question 13). When asked if the contact regular-class students have with mainstreamed students may be harmful, participants moved toward strongly disagree over the training period (question 15).

When asked if regular-classroom teachers have sufficient training to teach children with special needs the participants responded with undecided that was toward disagree (3.71) before the training and they were clearly undecided (3.11) after the training. It would appear that the training helped them realize that some of the skills and knowledge that they possessed related to early childhood education might be useful if and when they mainstream children in their classrooms.

While the participants were still undecided if it is likely that a special-needs child will exhibit behavior problems in a regular classroom setting the movement was toward them disagreeing with the statement (question 19). Again training may have made them question pervious attitudes about mainstreaming.

Participants moved in the direction of strongly disagree when asked if mainstreaming is likely to have a negative effect on the emotional development of the special-needs child (question 23). In their response to question 25, that the special-needs child will be socially isolated by regular classroom students, participants moved from almost disagree (3.84) to disagree (4.18).

Participants were close to undecided (2.77) when asked if they thought that integration of special-needs children would necessitate extensive retraining of regular teacher before the training (question 27). After the training participants reported that they were undecided, but moving toward disagree (3.32).

Finally, participants reported that pre-training they almost disagreed (3.71) with the statement that special-needs children are likely to create confusion in the regular classroom. However, they reported that they agreed, approaching strongly agree (1.38), with the statement after the training and practicum experience. This may be due to the fact that in their training and practicum experience that meeting the various needs may have been confusing to a novice.

It is encouraging to see positive movement of attitudes among the participants, and it remains to be researched if the attitudes will continue to change with experience with children with a disability and with time.

V. Project Impact

In reviewing the concepts, program, and results of the three year pilot project several topics have emerged of relevance to the design and administration of multidisciplinary training programs for day care providers. These topics were addressed in a proposal submitted to the Department of Health and Human Services, Administration for Children and Families to develop a three year Head Start-UAP Collaborative Training Project. The proposal was granted in October 1992 (Grant # 90-CD-0928). Thus the Project Lexington Multidisciplinary Inservice Training Model is being continued and expanded to address the following topics:

Discrepancy in approach and philosophy between regular and special education fields: During the first year of the training initiative the discrepancy between the special education and regular early childhood fields approach to early childhood education became a point of tension. In general the discrepancy was conceptualized by the project staff as differences in the content of teacher training programs.. In special education the focus is on individualized programming, emphasizing systematic instruction as proscribed by an Individualized Education Plan. In regular early childhood education the focus is on group programming, emphasizing developmentally appropriate curriculum, learning centers, and small group activities.

At the time the project was initiated, the gap between these two fields was just beginning to be broached. From this point, the project took the firm direction of 1) emphasizing the similarities between children with disabilities and all children; 2) the similarities between special education and regular early childhood education objectives for promoting child growth and development; and 3) integrating within the inservice curriculum approaches from both fields for working with children in early childhood education settings , which would be applicable to integrated day care programs. Essentially what emerged was a "collaborative consultation" inservice model, which respected the experience and knowledge of participants through bringing the knowledge and experience of special educators and therapists to day care providers, based on the day care providers priorities for developing their knowledge, skills and day care program. The day care providers became the"client" with the specialists becoming the "consultants".

By the end of the inservice program day care participants had learned both information and skills they had identified as important from the onset, as well as how specialized community resources could continue to be called-on for consultation when the day care providers needed additional information pertaining to particular children's needs within their program. In a very real sense, the training model provided for proactive training and technical assistance rather than providing simply prescriptions from a contained training package. The result was elimination of tension between "opposing" factions within the inservice sessions and continuing collaborative relationships between day care programs and specialized intervention and education agencies in the community.

Need for recognition of inclusive child care as separate from specialized early intervention, but equal in importance to working parents of children with disabilities. A major focus of current public policy regards inclusion of persons with disabilities in community as a civil right. It is not realistic, however, to assume that every community child care program will employee special educators and a therapy team, in order to provide day care for children with disabilities. It is realistic to assume that day care programs can be connected with specialists who can provide the training and consultation that day care staff will need to appropriately meet the particular needs of children with disabilities being served in their program. A primary assumption incorporated in the development of the Project Lexington inservice training model states that: "Day care workers should not be expected to be, or to become, special educators in order to be providers of day care/preschool programs, but rather be trained to participate as active members of early intervention or preschool service teams, communicate effectively with parents, and to translate therapeutic objectives into activities within an inclusive child care program". The Expanding Opportunities schematic (see page 7, identifies the coordinating mechanisms which need to be in place for community child care to be inclusive, along with the opportunities that may be developed in order to meet families community child care needs.

Funding mechanisms prohibiting transdisciplinary service provision and lack of service options. One of the most pervasive issues confronting the project staff was caused by the lack of flexible funding mechanisms for intervention services. "How do we pay for it?" became a recurring question. Once the participants developed their sense of "best-practice" for inclusive day care, the impediment became public funding policy. Some state resources are available for adapting family home environments to be accessible, but not for day care centers. Health insurance will pay for service provided in health care facilities or the child's home, but not for therapists to provide services on-site at the day care center. Special equipment funds will provide for equipment needed for the child in home or educational settings, but not in day care settings. The issue of how *to pay for inclusive day care*, has simply not been addressed in federal or state policy. The reality is that making inclusive day care affordable - is a more confounding issue than is providing effective inservice training and technical assistance.

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September 27, 1992

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Dear Early Childhood Colleague:

For the past three years IHDI-UAP, University of Kentucky, has been implementing a multidisciplinary inservice training program, to assist child care staff in the Lexington Bluegrass area develop knowledge and skills needed to provide integrated child care services to children in integrated, generic child care programs. The project was funded by the federal Department of Education, Office of Special Education Programs, Early Education Programs for Children with Disabilities.

As the project concludes, we are happy to be able to share the Project Lexington Curriculum Guide, with our Kentucky Early Childhood colleagues. The guide is not a detailed curriculum package, but instead a framework for developing and providing needs based inservice training to child care workers in regular early childhood programs. The framework could be used by Program Directors or Inservice Training consultants to develop a training program for individual centers or small groups of local child care programs. The framework is based on optimal practice guidelines of regular and special early childhood education fields, and represents a truly integrated approach to inservice training provision.

The package includes the following components:

Curriculum Framework - The curriculum framework focuses on extending knowledge and skills in five general areas of early childhood job functions. The framework includes knowledge, skill, and attitude competencies related to specific job responsibilities in each of these five areas.

Needs Assessment - Needs assessment includes a Center Program Components Checklist to be completed by program directors and Center-Based Training and Technical Assistance Needs Assessments, to be completed by staff participating in the inservice training program. Needs assessment materials are designed to coincide with the competency-based curriculum framework.

Evaluation - Evaluation includes a pre/post inservice Early Childhood Program Profile to be completed by the program directors; a pre/post inservice knowledge and attitude scale to be completed by inservice participants; a child care program observation format which can be used to observe related skill application within child care programs; and an inservice training session evaluation format.

Technical Assistance - Follow-up technical assistance is included as part of the inservice training program framework. Guidelines for technical assistance consultants, as well as technical assistance coordination and tracking forms are included.

Content Summary and Appendix - A content summary provides an overview of information related to each of the core early childhood functions. For the training team, the content summary provides a foundation for extending interactive learning activities for inservice training. The content summary provides inservice participants with a concise overview of information to be covered in the training program. The appendix sections coincide with the content summary. Some of the materials used in the Lexington area have been included in the appendix, however, additional materials were included (i.e. journal articles, local program information, etc.) depending on the identified training and technical assistance needs of the participants.

You are welcome to use any portion of the Project Lexington Training Manual, that will be helpful to you in expanding integrated child care opportunities in your area. If you would like to discuss development of the inservice training program in greater detail, please feel free to give me a call.

As Project Director, I have enjoyed the opportunity to collaborate with many excellent child care providers and inservice training and technical assistance consultants in the Lexington area, as they have worked together to expand child care opportunities to address the needs of children with disabilities in integrated child care programs. I hope that you will find these materials useful, as well.

Sincerely,

Becky H.

Rebecca Howe, Project Director
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Project Lexington Inservice Training

Expanding Community Child Care Opportunities For Children With Special Needs

Interdisciplinary Human Development Institute
University of Kentucky

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INTRODUCTION: PROJECT LEXINGTON INSERVICE TRAINING AND TECHNICAL ASSISTANCE PROGRAM

The Project Lexington Inservice Training Program is designed to provide early childhood professionals and paraprofessionals with the knowledge and skills needed for including children with disabilities in regular, generic, child care programs. The training focuses on extending knowledge and skills in five general areas of early childhood job functions. These areas are.

I. Provision of a nurturing child care environment
II. Working cooperatively with Parents
III. Coordination of assessment and program planning
IV. Planning and implementing curriculum
V. Ensuring compliance with Federal and State regulations and guidelines

Objectives:

1. To train child care personnel in skills needed to facilitate the integration of children with disabilities into generic child care settings.

2. To tailor the inservice training program to:
    a) meet the needs of participating child care facilities,
    b) meet the needs of individual participants,
    c) recognize the current roles and levels of experience of the participants.

3. To provide an incentive program to participating child care facilities which:
    a) encourages involvement in training, and/or
    b) recognizes the fiscal cost of releasing staff for extended periods of time.

Outcome:

As a result of participating in the Project Lexington Inservice Training Program, child care personnel will acquire attitudes and skills necessary to implement new roles as providers of services to both children with disabilities and typical children in integrated early childhood settings.

Approach to Project Lexington Training:

Coordination of Training Program -

The provision of inservice training and technical assistance will be coordinated by an early childhood education specialist. The inservice coordinator is responsible for: a) identification and selection of early child care programs to participate in the inservice program; b) meeting with program directors and staff to conduct needs assessment, coordinate training and technical assistance activities, and provide consultation as needed; c) identifying, selecting, and training the core training team; d) meeting with trainers to provide a written summary of participant training needs and to plan the training agenda; e) evaluating the inservice training program; d) summarizing participant's technical assistance needs; e) planning the follow-up technical assistance schedule including, selection of technical assistance consultants and evaluation of technical assistance process; and f) maintaining contracting and financial reimbursement records for participating centers, trainers, and technical assistance consultants.

Needs Assessment -

Inservice will begin with a center-based needs assessment to be completed by all levels of staff elected for training. Center directors will be asked to complete the Center Program Components Checklist. Each staff member who will be participating in the training program will complete the Inservice Training Needs Assessment. On completion of the classroom and practicum portion of the training programs, participants will complete the Follow-up Technical Assistance Needs Assessment.

Training Proposal -

Following completion and review of the needs assessment, a training proposal will be drafted addressing each programs training needs. This proposal will outline the specific objectives, and schedule of the training designed to meet each center's identified training and technical assistance needs.

Inservice Program Development -

To assure adaptability of training and technical assistance to individual needs, the results of the needs assessment will be used by the inservice coordinator to guide the adaptation of existing inservice training curriculum, select appropriate training and technical assistance consultants, and grouping participants according to the level and type of training requested. Selection of core trainers shall include a minimum of an early childhood educator and an early childhood intervention specialist. Parent participation on the core team is preferred. In addition, arrangements shall be made to invite an interdisciplinary/ transdisciplinary intervention team, as well as a parent panel, to provide training related to multidisciplinary intervention practices and parent priorities, concerns and resources, respectively. Technical assistance consultants will be selected according to participant priorities and consultant expertise.

Pre-Training Self-Study -

To help assure a common starting place in terms of values, language/terminology, and understanding of the needs of children with disabilities, a copy of the Project Lexington Inservice Content Summary will be given to each participant before the classroom training begins. The inservice training team will use the Content Summary as a starting place for developing the training activities related to participant priorities.

Structure of Inservice Program -

Classroom training will total twenty-two (22) hours, interspersed with twelve (12) hours of community-based practicum experience. The training will focus on methods for working with infants and children with disabilities in integrated early childhood settings. Classroom training will be provided by a core team of trainers and guest training consultants representing a variety of disciplines, to emphasize the value of a team approach to service provision. The training will be developed to include cooperative learning strategy.

Practicum experiences will be designed to provide participants with increased knowledge about local early intervention resources, as well as provide opportunity for supervised experience within an integrated childhood program.

Follow-up technical assistance will be developed to address priorities identified by the child care program director and individual participants.

Again, the specific training and technical assistance agendas will be guided by the results of the center and participant needs assessments. The general inservice schedule involves:

- six hours of classroom training on each of two Saturdays;.
- four evening training sessions at 2.5 hours each;
- twelve hours of community practicum, distributed in 1-2 hour sessions;
- six hours of follow-up consultation/technical assistance at each child care center.

In general the total training session extends over a six to eight week period. Adjustments to the inservice schedule may be made according to the needs of the child care programs participating in the training program.

Selection of Participants -

In selecting personnel to participate in the Inservice Training, we ask that center directors identify a variety of staff members who have responsibilities for areas such as: policy and procedure development, working directly with children birth-2 and/or 3-5 years of age (i.e. teachers and associate teachers), and working with parents (i.e. parent coordinators). Center Directors are encouraged to participate in the training with their staff. Additional consideration may be given to staff involved with monitoring children's health status, planning staff development activities, or other specialized functions important to child care service delivery within the center program.

Incentive Budget -

An amount of not less than two hundred dollars ($200.00) per trainee is recommended as the incentive payment to child care programs for staff participation in the intensive inservice program. Examples of acceptable spending categories include: staff incentive, substitute teachers, purchase of adapted equipment, facility/playground modification, professional materials, or other expenditures directly related to the development of the center's integrated child care program.

Evaluation -

Project Lexington includes an evaluation component developed to assist our teams of participants and trainers to achieve the goal of promoting the skills needed to facilitate the integration of children with disabilities into each center's program. The procedures for evaluation include:

a) Pre/post completion of the Early Childhood Program Profile by the child care center director;
b) Completion of a pre/post knowledge and attitude scale by staff participants; and
c) Completion of a child care program observation pre/post participation in the inservice program.

Project Lexington Curriculum Framework:

The following Inservice Curriculum Framework identifies core job responsibilities, knowledge, and skills necessary for the provision of quality early-childhood services to children with developmental disabilities in integrated early childhood settings, within the five areas of early childhood job functions listed previously:

I. Provision of a nurturing child care environment
II. Working cooperatively with Parents
III. Coordination of assessment and program planning
IV. Planning and implementing curriculum
V. Ensuring compliance with Federal and State regulations and guidelines

In addition to responsibilities, knowledge and skills, the attitudes that child-care staff hold about working with children having disabilities in an integrated child care setting are considered critical. Within each area of job responsibility the Curriculum Framework, therefore, includes a list of attitudes which should be incorporated in the design of the inservice training program.

The training and technical assistance needs assessments include each of the 29 basic skills listed in the curriculum framework. The framework includes additional knowledge and attitude competencies related to these skills. The curriculum framework should, therefore, be used by the inservice coordinator and training and technical assistance consultants as a guide for the inservice program development. As the inservice program is developed, related knowledge and attitude competencies should be included in planning the interactive training and technical assistance activities associated with the participants identified priority skill areas.

JOB FUNCTION I:

PROVISION OF A NURTURING CHILD CARE ENVIRONMENT

JOB FUNCTION I: Provide a nurturing child care environment, which integrates the interests, learning styles and physical attributes (qualities) of all children.

To fulfill this job function, early childhood personnel will:

Job Responsibility:

I.A Design an environment which meets the needs of individual children, within an integrated day-care setting.

Basic Knowledge

I.A.1 Learning center philosophy, age-appropriate learning materials, methods for using the environment as a teaching/learning tool.

I.A.2 Ways integrated service settings facilitate children's coping, socialization, self-confidence, and self-esteem.

Basic Skills:

I.A.3 Adapting settings, materials, and equipment to assure access for all children.

I.A.4 Promoting positive self-concept through opportunities for independence, making choices, initiating activities, imitation.

Basic Attitudes

I.A.5 A quality developmental child care program is designed around the qualities and needs of individual children - the child is not expected to "fit" a pre-defined program.

I.A.6 Integration is a basic human right -- when diversity in the classroom is identified and valued the quality of teaching improves for all.

I.A.7 By fostering positive self-regard and confidence we validate self-worth.

Job Responsibility:

I.B. Create and maintain an atmosphere of warmth, personal interest, enjoyment and calm throughout the facility.

Basic Knowledge

I.B.1 Principles of an environmental approach to behavior management.

Basic Skills:

I.B.2 Reflecting mutual respect by using methods of positive negotiation, active listening, shared problem solving.

I.B.3 Modifying the physical setting to encourage positive interactions.

Basic Attitudes:

I.B.4 Experience in developing enjoyable caring relationships with people having different abilities and experiences is a valuable skill, serving us well throughout our lives.

Job Responsibility:

I.C. Ensure that the environment is healthy and safe for all children.

Basic Knowledge:

I.C.1 Health and medical issues related to specific developmental disabilities

I.C.2 Medical technologies and assistive devices affecting health status.

I.C.3 Checklist for Center safety.

Basic Skills:

I.C.4 Attaining instruction in and implementing proper use of medications and assistive devices needed by individual children from licensed physicians or therapists.

I.C.5 Establish and conduct regular Center safety checks using a checklist for Center safety.

Basic Attitudes:

I.C.6 The proper use of medications and assistive devices for children with disabilities is critical to optimal cognitive, social, and emotional development as well as health maintenance.

I.C.7 A basic and ongoing ethical and legal responsibility of every child-care provider is establishing and maintaining a safe environment for children.

JOB FUNCTION II

WORKING COOPERATIVELY WITH PARENTS

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JOB FUNCTION II: Work cooperatively with parents, as partners in planning and coordinating services for children.

To fulfill this job function, early childhood personnel will:

Job Responsibility:

II.A. Assist parents in planning successful transitions between service settings.

Basic Knowledge:

II.A.1 Special services and agencies involved with families of children with disabilities.

II.A.2 Principles of family-focused intervention and interagency coordination.

II.A.3 Steps in effective transition planning process.

Basic Skills:

II.A.4 Recognizing and accommodating complex schedules of families of children with disabilities.

II.A.5 Avoiding service replication between service agencies.

II.A.6 Implementing transition plans designed to build on family strengths, assist families to coordinate their own children's services, and support families in accomplishing their goals.

Basic Attitudes

II.A.7 Professional behavior should reflect an understanding of the family experience, respect for need for flexibility and willingness to adjust to family needs.

II.A.8 Transition planning is an ongoing process, important for preparing children and parents for future settings.

II.A.9 Each family brings with them a unique set of circumstances, experiences, and cultural differences reflected in a unique set of priorities, strengths and values.

Job Responsibility:

II.B. Facilitate parent involvement in their child's center activities and individual program development.

Basic Knowledge:

II.B.1 Why parent involvement in assessment and planning is important for setting functional developmental goals and objectives.

II.B.2 Why and how parent involvement may vary across families, and over time for a given family.

Basic Skills:

II.B.3 Applying strategies for involving parents as team members and in taking active roles in assessment and program planning for their children.

II.B.4 Using parent inventories to assess children's daily routines in home and community settings and involving parents in identifying functional goals and objectives.

II.B.5 Sharing parent information with other staff members.

Basic Attitudes:

II.B.6 The people most familiar with a child's accomplishments and needs are family members.

II.B.7 When school and home retain similar goals for children, the child will be more likely to reach his/her full potential.

II.B.8 Considering ways to promote independence in home, school, and community settings is primary in the writing of meaningful goals and objectives.

Job Responsibility:

II.C. Train and support families in becoming effective long-term advocates for their children.

Basic Knowledge:

II.C.1 How to use parent-involvement as a training-tool to help parents validate their own ability to coordinate their children's services.

II.C.2 Concepts of family system dynamics, family-support, and parent-advocacy.

Basic Skills:

II.C.3 Encouraging and promoting parent decision making and planning for their children's special service needs.

II.C.4 Providing formal and informal parent education regarding parent/child relationships, transition planning and service coordination.

II.C.5 Identifying family strengths and building on these strengths to assist families to meet their needs.

Basic Attitudes:

II.C.6 The basic learning-resource for children is their family which include parents, siblings, extended family members and significant others.

II.C.7 Parents are vital members of the planning team and should be included, with staff, in shared goal setting and decision making.

JOB FUNCTION III:

COORDINATION OF ASSESSMENT AND PROGRAM PLANNING

JOB FUNCTION III: Ensure coordination between center staff assessment and program planning and that of specialized teams providing these services to children with disabilities and their families.

Job Responsibility:

III.A Work cooperatively with agencies and professionals involved in the development and implementation of Individual Family Service Plans (IFSP's) or Individual Education Plans (IEP'S).

Basic Knowledge:

III.A.1 Principles of team process, effective interpersonal communication, consultation and decision making.

III.A.2 The IFSP/IEP process and various disciplinary team models.

III.A.3 Roles of various disciplines and agencies involved in the service delivery process.

Basic Skills:

III.A.4 Using effective team process skills to maintain positive working relationships with parents, professionals and children.

III.A.5 Maintaining communication between the Center staff and team members involved in the IFSP/IEP process.

Basic Attitudes:

III.A.7 Willingness to accept advice and share knowledge/information are essential to effective team process.

III.A.8 Effective early intervention requires cooperation among multiple disciplines and involves shared information strategies, and techniques.

Job Responsibility:

III.B. Develop and implement an individual education plan for each child with disabilities or believed to be at developmental risk.

Basic Knowledge:

III.B.1 Advanced knowledge of normative and atypical development.

III.B.2 Applied knowledge of systematic observation skills.

III.B.3 Familiarity with accepted assessment methodologies.

III.B.4 Steps in writing functional goals and objectives.

III.B.5 Procedures for data management and evaluation to measure child and program change across domains.

Basic Skills:

III.B.6 Using formal and informal observation techniques to evaluate child development progress.

III.B.7 Choosing and administering appropriate developmental assessment instruments.

III.B.8 Interpreting and integrating recommendations of therapeutic staff involved with IFSP/IEP assessments within Center based IEP development.

III.B.9 Writing functional goals and objectives for each development area for which assessment has indicated a need for improvement.

Basic Attitudes:

III.B.10 Decisions about IEP goals and objectives need to be based on a child's ability to function in a given environment, rather than on a given diagnostic label.

III.B.11 Therapeutic goals need to be infused within ongoing regular routines and activities, so that a child practices skills throughout the day.

JOB FUNCTION IV:

PLANNING AND IMPLEMENTING CURRICULUM

JOB FUNCTION IV: Plan and implement a functional curriculum to meet the total needs of the child.

Job Responsibility:

IV.A. Translate IFSP/IEP goals and objectives into daily curriculum plans.

Basic Knowledge:

IV.A.1 Methods for translating functional goals/objectives into natural age-appropriate curriculum plans.

IV.A.2 Principles of sequenced skill development, distributed practice, incidental learning, and embedded basic skill training.

IV.A.3 Instructional strategies to ensure peer interaction among children having varied developmental levels.

Basic Skills:

IV.A.4 Selecting age-appropriate activities which reflect the child's family and cultural setting.

IV.A.5 Embedding basic skill training in real (e.g. functional, normal, age-appropriate activities).

IV.A.6 Increasing the type and degree of interaction among children with disabilities and typical children.

Basic Attitudes:

IV.A.7 Curriculum planning should direct attention to all developmental areas, creating opportunities for growth in a rich and varied environment.

IV.A.8 The criteria of optimal functioning focuses on skills a child needs to participate productively and independently across community settings.

IV.A.9 The basic needs of all children are universal, therefore participation of children with disabilities with their peers, in all age-appropriate activities is expected and should be encouraged.

Job Responsibility:

IV.B Encourage the generalization of skills to future community settings.

Basic Knowledge:

IV.B.1 Ways curriculum design and service delivery models influence children's participation in future educational and social settings.

Basic Skills:

IV.B.2 Identifying adaptive "survival" skills needed to function in current and future academic and social situations.

IV.B.3 Developing curriculum objectives and activities to include adaptive skills, with cues and corrective procedures that will be used in future community settings.

Basic Attitudes:

IV.B.4 The structure and curriculum of the early childhood setting will influence the success a child experiences in current and future community settings.

IV.B.5 The ultimate goal of early education services are to enable children to be happy, have friends, live and play in the community, and become a productive member of society.

JOB FUNCTION V:

ENSURING COMPLIANCE WITH FEDERAL AND STATE REGULATIONS AND GUIDELINES

JOB FUNCTION V: Ensure compliance with Federal and State regulations and guidelines related to the provision of early childhood education for children ages 0-5 with disabilities.

Job Responsibility:

V.A Comply with state and local regulations for facilities, staff, and services of early childhood centers.

Basic Knowledge:

V.A.1 State Department of Licensure regulations governing the licensing and registering of child care centers.

V.A.2 Local ordinance and codes governing running a day care program including zoning, fire, building and health standards.

V.A.3 State and local abuse and neglect reporting process.

Basic Skills:

V.A.4 Maintain accurate records and files pertaining to child/family service delivery required by law.

Basic Attitudes:

V.A.5 Regulations governing program and practice serve the purpose of supporting and protecting both staff and program participants.

Job Responsibility:

V.B Comply with Federal and State guidelines related to the delivery of early childhood services to children with disabilities.

Basic Knowledge:

V.B.1 Requirements of PL 95-602, PL 94-142, and PL 99-457 related to services for children with disabilities.

V.B.2 Principles of normalization, early intervention, least restrictive environment.

Basic Skills:

V.B.3 Describe the importance of public law early education regulations for children with disabilities, and the implications for children served in integrated day care settings.

V.B.4 Develop written policy statement describing Center program and philosophy supporting the principles of normalization, early intervention, and least restrictive environment.

Basic Attitudes:

V.B.5 The policy established in PL 99-142, PL 99-457 and PL 95-602, related to services to people with disabilities represent landmark legislation; broadly defined these acts uphold the rights of children with disabilities to: free and appropriate education, special services tailored to meet individual needs, and services designed to maximize each individuals developmental potential.

REFERENCES:

Middendorf, K (1989) A Taxonomy of Job Functions and Related Competencies for Staff of Community Agencies Serving Persons with Developmental Disabilities. IHDI, University of Kentucky, Lexington.

Peterson, N.L. (1987). Chapter 11: Program Planning, Teaching, and Interdisciplinary Considerations (Pp. 447-491) in Early Intervention for Handicapped and At-Risk Children. Denver: Love Publishing.

Office of Education for Exceptional Children (1989), SHIPP Philosophies. Frankfort: Cabinet for Human Resources, Kentucky Deaf-Blind Intervention Program.

Growing Together Preschool (1989) Personal Correspondence. "Expectations of the Integrated Day Care Worker".

Jordan, J. et al (1988). Competencies of Infant Specialists (Pp. 152-160) in Early Childhood Special Education: Birth to Three. ERIC

Garwood and Fewell (1983). Exhibit 8-1 (P 317) In Educating Handicapped Infants. Aspen Publishers.

Hartley, M. et al (1989). The Challenges of Providing Quality Group Care Child Care for Infants and Young Children with Special Needs. Infants and Young Children 2(2): 1-10. Aspen Publishers.

Kilgo, J.L. et al (1989). Teaming for the Future: Integrating Transition Planning with Early Intervention Services for Young Children with Special Needs and Their Families. Infants and Young Children 2(2): 37-48. Aspen Publishers.

McDonnell, A. and Hardman, M. (1988). A synthesis of "Best Practice" Guidelines for Early Childhood Services. Journal of the Division for Early Childhood, V. 12, #4: 328-341.

PROJECT LEXINGTON INSERVICE PROGRAM
NEEDS ASSESSMENT FORMS

- Training and Technical Assistance Center Program Components Checklist
- Early Childhood Staff Training Needs Assessment
- Follow-up Technical Assistance Needs Assessment
- Summary of Priority Training and Technical Assistance Needs

Training and Technical Assistance Center Program Components Checklist

TRAINING AND TECHNICAL ASSISTANCE CENTER PROGRAM COMPONENTS CHECKLIST

The purpose of this checklist is to provide you with a systematic tool for the review of your center's program components, as you develop and expand your early-integrated child care services. The items included in the checklist are common to many early integrated child care programs. The checklist will assist you to a) identify areas that are relevant to your program; b) identify those areas in which further development is needed; and c) define those areas in which outside training or technical assistance is desired.

The five major sections of the checklist correspond to functional job categories considered important for integrated early childhood programs. These include Child Care Environment; Working with Parents; Assessment and Program Planning; Curriculum Planning and Implementation; and Compliance with State/Federal Regulations.

To complete the survey, read each item carefully, and:

I. Decide whether the item is relevant for your program. If you do not consider the item relevant, circle "0" on the rating scale and move on to the next item.

II. If the item is considered relevant, rate the item either:

"1" - Must Be Considered and Planned - (You consider the item important for developing your program, but work to implement the item has not begun).

"2" Task Partly Completed - (Your staff have started working to address the item).

"3" Task Completion/In Operation - (The item is in place, and no additional work to complete the task is needed).

III. If the item is rated either "1" or "2", decide whether the item can be addressed using your center resources. If you decide that outside assistance is needed, please identify whether you believe training or consultation/technical assistance would be most helpful, by placing a check mark in the appropriate box.

IV. After completing the checklist, please list five items for both training and technical assistance which you consider to be the most important for your center's development of early-integrated child care services on the forms provided.

RATING SCALE

0/NR = "Not Relevant for Our Center's Program"
1/CP = "Must Be Considered and Planned"
2/TPC = "Task Partly Completed"
3/TC0 = "Task Completed/In Operation"
TR = "Need for Training"
TA = "Need for Technical Assistance/ Consultation

INSERVICE TRAINING AND TECHNICAL ASSISTANCE
CENTER PROGRAM COMPONENTS CHECKLIST

I.	Child Care Environment	NR	CP	TPC	TCO	TR	TA
1.	Our Center's indoor and outdoor environment is:						
	a. . . pleasant for the children and their families.	0	1	2	3	____	____
	b. . .appropriate to the children's' developmental needs.	0	1	2	3	____	____
	c. . .appropriate to center program goals and objectives.	0	1	2	3	____	____
2.	We have defined procedures for obtaining medical consultation in order to appropriately manage the medical needs of children.	0	1	2	3	____	____
3.	We have defined procedures for conducting center safety checks.	0	1	2	3	____	____
4.	Our physical facility has been designed and/or prepared for conducting an integrated day care program.	0	1	2	3	____	____

		NR	CP	TPC	TCO	TR	TA
5.	Our center staff have considered the principle of providing services in the least restrictive environment (LRE), and the implications of this principle for serving children in an integrated day care setting.	0	1	2	3	____	____
6.	Supplies and equipment have been purchased/ adapted to meet the varied needs of children within an integrated day care setting.	0	1	2	3	____	____
7.	We have considered the transportation needs of children with disabilities, and we have implemented transportation services to meet the needs of children and their families.	0	1	2	3	____	____

II. Working With Parents

		NR	CP	TPC	TCO	TR	TA
8.	Our center has a written statement describing our philosophical/theoretical approach to:						
	a. . . . . .children's services.	0	1	2	3	____	____
	b. . . . . . . .services to children with disabilities.	0	1	2	3	____	____
	c. . . . . family services.	0	1	2	3	____	____

		NR	CP	TPC	TCD	TR	TA
9.	Our center has written goals and objectives for program services to children and families	0	1	2	3	____	____
10.	Procedures for soliciting family input on service priorities and desired goals and outcomes are regularly implemented.	0	1	2	3	____	____
11.	Family needs, expressed interests, and schedules are considered in developing and providing direct services.	0	1	2	3	____	____
12.	Our center has established admission criteria, procedures and materials (e.g. written eligibility criteria, an orientation for children and their families.	0	1	2	3	____	____
13.	Our center has established referral procedures for children who were not admitted to our program.	0	1	2	3	____	____
14.	Both our staff and parent orientation procedures include a clear description of the center's philosophy, goals, and objectives related to family services as well as children's' services.	0	1	2	3	____	____
15.	Procedures for assisting children and families make the transition into our program and/or into future programs are established and implemented, as needed.	0	1	2	3	____	____

		NR	CP	TPC	TCO	TR	TA
16.	Our center's transition procedures include strategies for facilitating:						
	a. . . . . timely information/records exchange	0	1	2	3	____	____
	b. . . . . follow-up contacts between programs	0	1	2	3	____	____
	C. . . . . placement in the least restrictive environment						
17.	Direct services for families are implemented and ongoing.	0	1	2	3	____	____
18.	Materials and/or curricula for implementing our center's family services program have been acquired and/or developed.	0	1	2	3	____	____
19.	There are opportunities for family members to be involved in center activities other than receiving direct services (e.g. social activities, serving as advisory members or volunteers, etc.).	0	1	2	3	____	____
20.	Data are being collected to document the extent to which families have been involved in direct service and/or other center activities.	0	1	2	3	____	____
21.	Our center uses valid and reliable instruments for evaluating parent satisfaction with program services	0	1	2	3	____	____
		NR	CP	TPC	TCO	TR	TA

III. Assessment and Program Planning

22. Our center maintains written documentation of the number and types of children to be served, including age range, handicapping condition and/or risk factors (when appropriate), and other characteristics important to program planning.	0	1	2	3	____	____
23. Our center maintains an individual record/file for each child.	0	1	2	2	____	____
24. Appropriate and non-discriminatory screening/assessment procedures are scheduled and implemented for each child.	0	1	2	3	____	____
25. When indicated, intervention planning for each child is data-based, with reliable assessments of progress implemented according to established time lines.	0	1	2	3	____	____
26. A procedure for assessing family strengths and needs has been identified and is being implemented by center staff.	0	1	2	3	____	____
27. Procedures for securing services for children and their families through other agencies have been implemented, including procedures for assuring ongoing communication and cooperation between families and agency service providers.	0	1	2	3	____	____
	NR	CP	TPC	TCO	TR	TA

28.	Our center staff regularly communicate/collaborate with other agencies serving our program families.	0	1	2	3	____	____
29.	Our center has established procedures for negotiating relationships/agreements with other agencies.	0	1	2	3	____	____
30.	Standard procedures and forms for documenting contacts, referrals and other coordinated activities with other outside agencies have been developed and are being used regularly.	0	1	2	3	____	____
31.	Our center routinely collects data to:						
	a. . . . document services provided to children and families by external agencies.	0	1	2	3	____	____
	b. . . . document that these services have been obtained by the family.	0	1	2	3	____	____
	c. . . . evaluate the extent to which each child has attained objectives of an IFSP/IEP.	0	1	2	3	____	____

IV. Curriculum Planning and Implementation

32.	An organizational chart outlining staff responsibilities and coordination is available.	0	1	2	3	____	____
		NR	CP	TPC	TCO	TR	TA
33.	Our staff understand each member's roles and	0	1	2	3	____	____

	responsibilities across all components of our program.						
34.	Scheduled staff meetings for planning, progress review, and communication purposes are ongoing.	0	1	2	3	____	____
35.	At least one staff member per classroom has received some training in the delivery of early childhood services to children with disabilities.	0	1	2	3	____	____
36.	An over-all curriculum approach for intervention has been developed and is being implemented.	0	1	2	3	____	____
37.	Sufficient curriculum materials have been acquired or adapted to carry out the center's intervention program.	0	1	2	3	____	____
38.	Internal and external assessment information is available to staff for instructional decision making.	0	1	2	3	____	____
39.	A record-keeping system is in place to record and document progress toward meeting individual instructional objectives for each child involved in an intervention program.	0	1	2	3	____	____

V. Compliance with State-Federal Regulations

		NR	CP	TPC	TCO	TR	TA
40.	Our program has a written statement assuring client's rights are protected including: informed consent, due process, and confidentiality.	0	1	2	3	____	____
41.	Center records and filing systems are in place to maintain accurate documentation of compliance with State and local regulations governing provision of center-based early childhood services.	0	1	2	3	____	____
42.	The center has determined state and federal reporting requirements and is routinely contributing data to local, state and federal efforts such as child-find, child-counts, directories, or tracking systems.	0	1	2	3	____	____
43.	Procedures which conform to federal, state and local guidelines have been planned and implemented to develop an individualized education program (IEP) for each child aged three and older or an individualized family service plan (IFSP) for families with children aged 0-2.	0	1	2	3	____	____

Source: Adapted from NEC*TAS Early Intervention Program Self-Assessment Form

Early Childhood Staff Training Needs Assessment

EARLY CHILDHOOD STAFF
TRAINING NEEDS ASSESSMENT

The purpose of the training needs assessment is to assist Project Lexington staff to design inservice training objectives appropriate for your particular child care program responsibilities. This information will also be used for research purposes associated with Project Lexington Grant objectives.

ALL INFORMATION IS CONFIDENTIAL. Aggregate information will be compiled for all child care staff participating in Project Lexington Inservice Training. This information will be used to assess the overall effect of the inservice training program for meeting staff training needs.

To complete the questionnaire:

This training needs assessment should be completed by each staff member participating in Project Lexington inservice training. A section is provided at the end of the formal training needs assessment for your additional training suggestions or comments. When you have completed the assessment, please return it to Project Lexington in the enclosed postage paid envelope.

If you have any questions regarding the completion of this questionnaire, you may contact:

Kim Townley, Ph.D. - 257-7732
University of Kentucky
Early Childhood Program

or

Becky Howe, Project Director - 257-5219
Project Lexington
IHDI
University of Kentucky

Thank you for your interest and effort!

INSTRUCTIONS: The items below identify some of the basic skills needed to plan and implement comprehensive services for young children with disabilities and their families within a regular/generic child care setting.

To complete the survey please write the number that best represents your current level of experience in the space provided.

RATING SCALE:

0 = "does not apply to my job description"

1 = "would like to do - need training"

2 = "now do, but would like to do better - training would be nice

3 = "now do - no need for further training"

A note on terms:

"Children With Disabilities" - The term "disability" is used to designate a broad range of diagnostic conditions. For example, terms used by specialists such as developmental delay mental retardation cerebral palsy or hearing impaired, among others, could be included in the general category of "disability".

"IFSP/IEP" - The initials "IFSP" refer to Individual Family Service Plan. IFSP'S are developed by a multi-professional team of early intervention specialists who may be working with families of children between the ages of birth and three years of age, identified to have some type of developmental delay.

The initials "IEP" refers to Individual Education Plan. IEP's are also developed by multi-professional teams. By 1991, IEP's will be required for all children with an identified developmental disability, who are between the ages of three to twenty-one. (Prior to 1991, IEP's were required between the ages of 6-21 years.)

A parent of a child with disabilities will always be included as a full member of the IFSP/IEP Team.

Date:________________________

SS#:________________________

HOW CAN WE HELP?......

_____ 1. Adapt settings, materials, and equipment to assure access to all children, including children with disabilities. (I.A.3)

_____ 2. Promote positive self-concept by providing children with ongoing opportunities for independence, making choices, initiating activities, and imitation. (I.A.4)

_____ 3. Reflect mutual respect by using methods of positive negotiation, active listening, and shared problem solving. (I.B.2)

_____ 4. Can modify the physical setting to encourage positive interactions between children. (I.B.3)

_____ 5. Attain instruction in how to properly use medications and/or assistive devices needed by individual children from licensed health care providers or therapists. (I.C.4)

_____ 6. Conduct regular center safety checks using a checklist for center safety, which is based on the needs of individual children. (I.C.5)

_____ 7. Recognize, and try to accommodate, the complex schedules of families of children with disabilities. (II.A.4)

_____ 8. Avoid service replication between our center services and those provided by other agencies working with families or children. (II.A.5)

_____ 9. Implement transition plans between services which are designed to: a) build on family strengths, b) assist families to coordinate their own children's services, and c) support families in accomplishing their goals. (II.A.6)

_____ 10. Involve parents in taking active roles in assessment and program planning for their children (II.B.3)

_____ 11. Regularly involve parents in identifying functional goals and objectives for their children by using parent inventories to assess children's daily routines in home and community settings. (II.B.4)

_____ 12. Share parent information with other staff members for purposes of program/curriculum planning, during regularly scheduled staff meetings. (II.B.5)

_____ 13. Encourage and promote parent decision making and planning for their children's special service needs. (II.C.3)

_____ 14. Provide formal or informal parent education regarding parent/child relationship transition planning, and service coordination. (II.C.4)

_____ 15. Identify family strengths, and build on these strengths to assist families to meet their needs. (II.C.5)

_____ 16. Use effective team process skills to maintain positive working relationships with parents, professionals and children. (III vs > A.4)

_____ 17. Maintain communication between the center staff and team members involved in the IFSP/IEP process. (III.A.5)

_____ 18. Use formal and informal observation techniques to evaluate child development progress. (III.B.6)

_____ 19. Choose and administer appropriate developmental assessment instruments. (III.B.7)

_____ 20. Interpret and integrate recommendations of therapeutic staff involved with IFSP/IEP assessments within center based individual program planning. (III.B.8)

_____ 21. Write functional goals and objectives for each developmental area for which assessment has indicated a need for improvement. (III.B.9)

_____ 22. Select age-appropriate activities which reflect the child's family and cultural setting. (IV.A.4)

_____ 23. Embed basic skill training in real, functional, normal, age-appropriate activities (Example: learning center or field trip experiences which happen to include counting activities). (IV.A.5)

_____ 24. Use planned strategies to increase the type and degree of interaction among children with disabilities and nondisabled children. (IV.A.6)

_____ 25. Use a reliable method to identify children's level of attaining adaptive "survival" skills, which will be needed to function in current and future academic and social settings. (IV.B.2)

_____ 26. Develop curriculum objectives and activities to include adaptive skills, and use cues and corrective procedures that will be used in future community settings. (IV.B.3)

_____ 27. Maintain accurate records and files pertaining to child/family service delivery, required by law. (V.A.4)

_____ 28. Can describe the importance of public law early regulations for children with disabilities, and the implications for children served in integrated child care settings. (V.B.3)

_____ 29. Have developed written policy statement(s) describing center program and philosophy supporting the principles of normalization, early intervention, and least restrictive environment. (V.B.4)

_____ 30. Please list the numbers representing your top five priorities for training in the spaces provided:

1. #_______
3. #_______
5. #_______
2. #_______
4. #_______

ADDITIONAL TRAINING NEEDS OR COMMENTS:

THANK YOU.

Follow-up Technical Assistance Needs Assessment

PROJECT LEXINGTON PLANNING SESSION:

Project Lexington Inservice Training has been designed to:

Increase day care opportunities for children with disabilities in community day care programs; by helping day care providers develop the skills needed to meet the special needs of a child with disabilities in regular child care settings.

Because of this dual goal: to teach skills and to increase opportunities, the training wouldn't be complete without some time spent on plans to implement the training.

Are you ready, and confident to work with children with disability and to meet their individual needs? Is your program environment ready -- do you have books that include children with disabilities with their peers in regular activities? Do you have resources to assist you in planning and adapting child care activities so that children with various disabilities can be fully included in your programs ongoing child care program? Do you feel confident in planning adapted activities, working with parents as partners in planning or extending individualized activity plans, working with specialists in your classroom to learn special techniques to help children learn functional skills identified in their IEP/IFSP?

Project Lexington training does not end here -- Project Lexington staff will be meeting with each of you, or your program director, to arrange for 6 additional hours of technical assistance, on any area that you think you want or need additional information, in order to provide quality services to children with disabilities in your classroom.

Technical assistance is a broad term -- you may decide that you want more information on working with children with a specific kind of disability; you may want to further develop skills related to social development or adapted communication techniques; you may want help in developing a process for insuring effective communication with specialists working with a child; you may be really excited about this training and want to know how parents of children with disabilities will know that your classroom is waiting to meet their community child care needs. Or, you may think that it would be most helpful if Project Lexington staff offered several short inservice sessions on topics that you found particularly helpful, to other staff or parents assisting in your classroom. It's up to you.

Planning will include three steps:

1) Self-assessment of your current skills, by revisiting the original needs assessment tool.

2) Identification of information or skill areas in which you would like to have some additional 1:1 technical assistance.

3) Completion of an individual action plan, outlining how you plan to apply your knowledge and skills in serving children with disabilities in your classroom.

Project Lexington Training and Technical Assistance Needs Assessment

Name: ____________________
ID#: ____________________
Date: ____________________
Center: ____________________

ARE YOU READY AND CONFIDENT TO:

Instructions: Mark Y (yes) or N (no) in the space provided.

_____ 1. Adapt settings, materials, and equipment to assure access to all children, including children with disabilities.

_____ 2. Promote positive self-concept by providing children with ongoing opportunities for independence, making choices, initiating activities, and imitation.

_____ 3. Reflect mutual respect by using methods of positive negotiation, active listening, and shared problem solving.

_____ 4. Modify the physical setting to encourage positive interactions between children.

_____ 5. Attain instruction in how to properly use medications and/or assistive devices needed by individual children from licensed health care providers or therapists.

_____ 6. Conduct regular center safety checks using a checklist for center safety, which is based on the needs of individual children.

_____ 7. Recognize, and try to accommodate, the complex schedules of families of children with disabilities.

_____ 8. Avoid service replication between our center services and those provided by other agencies working with families or children.

_____ 9. Implement transition plans between services which are designed to: a) build on family strengths, b) assist families to coordinate their own children's services, and c) support families in accomplishing their goals.

_____ 10. Involve parents in taking active roles in assessment and program planning for their children.

_____ 11. Regularly involve parents in identifying functional goals and objectives for their children by using parent inventories to assess children's daily routines in home and community settings.

_____ 12. Share parent information with other staff members for purposes of program/curriculum planning, during regularly scheduled staff meetings.

_____ 13. Encourage and promote parent decision making and planning for their children's special service needs.

_____ 14. Provide formal or informal parent education regarding parent/child relationships, transition planning, and service coordination.

_____ 15. Identify family strengths, and build on these strengths to assist families to meet their needs.

_____ 16. Use effective team process skills to maintain positive working relationships with parents, professionals and children.

_____ 17. Maintain communication between the center staff and team members involved in the IFSP/IEP process.

_____ 18. Use formal and informal observation techniques to evaluate child development progress.

_____ 19. Choose and administer appropriate developmental assessment instruments.

_____ 20. Interpret and integrate recommendations of therapeutic staff involved with IFSP/IEP assessments within center based individual program planning.

_____ 21. Write functional goals and objectives for each developmental area for which assessment has indicated a need for improvement.

_____ 22. Select age-appropriate activities which reflect the child's family and cultural setting.

_____ 23. Embed basic skill training in real, functional, normal, age-appropriate activities (Example: learning center or field trip experiences which happen to include counting activities).

_____ 24. Use planned strategies to increase the type and degree of interaction among children with disabilities and nondisabled children.

_____ 25. Use a reliable method to identify childrens' level of attaining adaptive "survival" skills, which will be needed to function in current and future academic and social settings.

_____ 26. Develop curriculum objectives and activities to include adaptive skills, and use cues and corrective procedures that will be used in future community settings.

_____ 27. Maintain accurate records and files pertaining to child/family service delivery, required by law.

_____ 28. Describe the importance of public law early regulations for children with disabilities, and the implications for children served in integrated child care settings.

_____ 29. Develop written policy statement(s) describing center program and philosophy supporting the principles of normalization, early intervention, and least restrictive environment.

_____ 30. Please list the numbers representing your top five priorities for additional technical assistance:

1. # ________ 3. # ________ 5. # ________
2. # ________ 4. # ________

OTHER TOPICS OR TA REQUESTS:

A. ____

B. ____

C. ____

D. ____

31. If you answered "N" on any of the questions (1-30), enter the number of that skill area in a box below and describe what steps need to be taken in order for you to feel: Ready and confident to..."apply the skill", in your early-childhood program.

32. Action Plan: Describe in the space provided, at least five (5) actions you plan to take within the next six (6) months, to apply the skills you have developed in working with children with disabilities in your early childhood classroom/program.

Action Step:

Action Step:

Action Step:

Action Step:

Action Step:

Action Step:

Action Step:

Action Step:

THANK YOU!

Summary of Priority Training and Technical Assistance

PROJECT LEXINGTON: Summary of Priority Training and Technical Assistance
Child Care Center/Staff Needs and Activity

Child Care Center: ____________________ **Director:** ____________________

Administrator Completing Program Components Checklist
Name: ____________________
Phone: ____________________
Date: ____________________
Comment: ____________________
____

Address: ____________________
____
____

Phone: ____________________

Staff Participating in Project Lexington Training: (Date)

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________
11. ____________________
12. ____________________

Summary of Administrative Priorities for Training and Technical Assistance ____________________
____
____
____
____
____

Summary of Staff Training and Technical Assistance: Needs and Activity

Staff Training Needs (Pre-Classroom Training)	**Staff TA Needs** (Post-Classroom Training)	**TA: Summary of Activities**
Name:__________ Date:________ Priority Training Needs: Additional Training Needs: *Note: All identified training needs met other than:*	Date:________ Priority TA Needs: Additional TA Needs:	

SIX MONTH ACTION PLAN:

PROJECT LEXINGTON INSERVICE PROGRAM TRAINING FORMATS

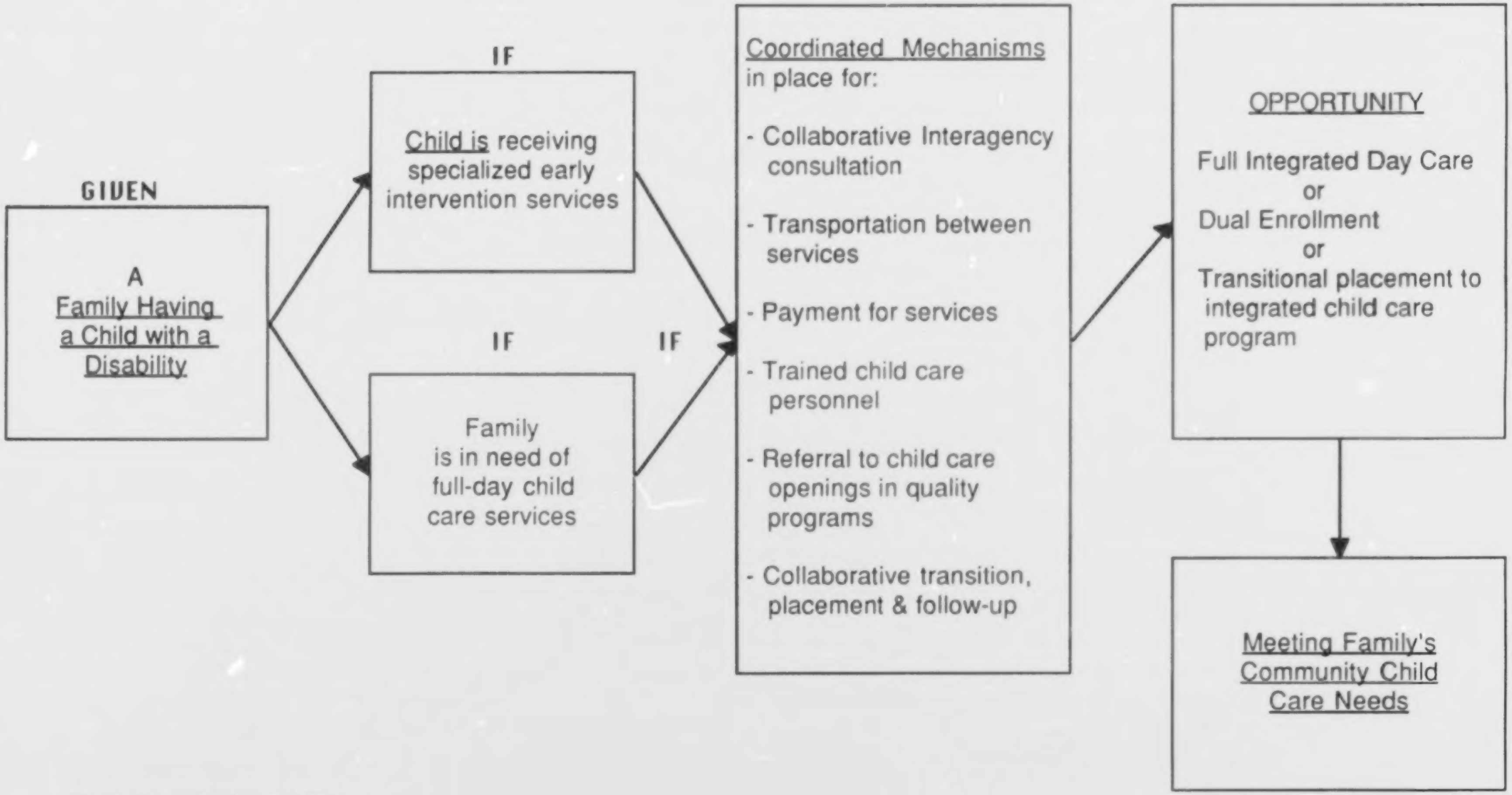
- Expanding Opportunities Conceptual Model
- Project Lexington Inservice Training Participating Staff Roster
- Basic Integrated Day Care Skills: Sample Inservice Training Goals and Objectives
- Inservice Presentation Format Form
- Sample Inservice Training Evaluation Form

Project Lexington Inservice Training Program:

Expanding Opportunities Conceptual Model

EXPANDING OPPORTUNITIES

For Community Day Care Services to Families of Children with Disabilities



GIVEN

A Family Having a Child with a Disability

IF

Child is receiving specialized early intervention services

IF

Family is in need of full-day child care services

IF

Coordinated Mechanisms in place for:

- Collaborative Interagency consultation
- Transportation between services
- Payment for services
- Trained child care personnel
- Referral to child care openings in quality programs
- Collaborative transition, placement & follow-up

OPPORTUNITY

Full Integrated Day Care
or
Dual Enrollment
or
Transitional placement to integrated child care program

Meeting Family's Community Child Care Needs

Project Lexington: 6/90

Project Lexington Inservice Training
Participating Staff Roster

PROJECT LEXINGTON INSERVICE TRAINING

Participating Staff Roster

INSTRUCTIONS:

Section A - Each program participating in Project Lexington must agree to select staff for training without regard to: race, color, national origin, gender, age, or handicapping condition. In accordance with this policy, please read and sign the equal opportunity statement in Section A.

Section B - Please provide the information requested for each staff member who will be participating in the Project Lexington Inservice Training scheduled for ____________________.

SECTION A: EQUAL OPPORTUNITY STATEMENT

As the Director/Administrator of ______________________________,
(Your agency/center)
I hereby confirm that staff listed in Section B of this document, were selected to participate in Project Lexington Inservice Training in accordance with standard equal opportunity practice, without regard to race, color, national origin, gender, age, or handicapping condition.

____
Signature

SECTION B: INSERVICE TRAINING STAFF LISTING FOR: ________________________

Date: ____________________

Agency/Center: ______________________________________

Staff Participating in Project Lexington Inservice Training will include:

a. Name ____
Current Position ______________________________________
Address: ____
Phone: (W) ____________________ (H) __________________

b. Name ____
Current Position ______________________________________
Address: ____
Phone: (W) ____________________ (H) __________________

c. Name ____
Current Position ______________________________________
Address: ____
Phone: (W) ____________________ (H) __________________

d. Name ____
Current Position ______________________________________
Address: ____
Phone: (W) ____________________ (H) __________________

e. Name ____
Current Position ______________________________________
Address: ____
Phone: (W) ____________________ (H) __________________

Basic Integrated Day Care Skills
Inservice Training
Goals and Objectives

BASIC INTEGRATED DAY CARE SKILLS
-INSERVICE TRAINING-

GOALS AND OBJECTIVES FOR UNIT I
WHAT IS A DEVELOPMENTAL DISABILITY

Goal: Participants will increase their knowledge of developmental disabilities, and become more aware of their own attitudes toward children with disabilities.

Objective I	History of Attitudes and Services for children with disabilities	1. Recognize myths about developmental disabilities 2. Be aware of service trends related to the education of young children with disabilities.
Objective II	The Developmental Disabilities Act and Related Jargon	1. Identify the major components of the Developmental Disabilities Act 2. Understand terminology used by service providers working with children with disabilities.
Objective III	Major categories of Developmental Disabilities	1. Recognize major categories of disabilities and their causes. 2. Understand the implications of having a disability for participating in age-appropriate community settings.
Objective IV	Disadvantages and Advantages of labeling	1. Recognize the possible use and misuse of diagnostic labels.

GOALS AND OBJECTIVES FOR UNIT II
CHILD CARE ENVIRONMENT

GOAL: Participants will increase their knowledge and ability to create a nuturing child care environment, which integrates the interests, learning styles and physical characteristics (qualities) of all children.

Objective 1:	How to set the Stage for Integrated Day Care	1. Recognize how basic concepts of early childhood education apply to working with children with disabilities. 2. Identify ways integrated settings facilitate children's social development. 3. Adapt the environment to meet children's individual needs. 4. Identify ways to promote positive self-concept of children with disabilities.
Objective II	How to Maintain A Friendly Atmosphere	1. Identify principles of an environmental approach to behavior management. 2. Use positive methods of negotiation and problem solving. 3. Modify the physical environment to encourage positive interactions.
Objective III	How to Ensure Health and Safety for All Children	1. Understand health and medical issues related to specific disabilities. 2. Access instruction on the proper use of medications or assistive devices from qualified professionals. 3. Develop and implement a checklist for center safety.

GOALS AND OBJECTIVES FOR UNIT III
PLANNING CURRICULUM

GOAL: Participants will increase their ability to plan and implement a functional curriculum to meet the total needs of the child, including the special needs of children with disabilities.

Objective I	Translating Goals and Objectives Into Curriculum Plans	1. Understand procedures for translating functional goals/objectives into curriculum plans. 2. Apply basic special education techniques to enhance functional skill development during regular activities. 3. Increase the type and degree of interaction among children with disabilities and typical children.
Objective II	Planning for Future Community Settings	1. Identify ways curriculum design influences children's participation in future settings. 2. Identify adaptive/"survival" skills needed in current and future set settings. 3. Include curriculum objectives and activities to promote adaptive skills for future settings.

GOALS AND OBJECTIVES FOR UNIT IV
WORKING WITH PARENTS

GOAL: Participants will increase their ability to work cooperatively with parents, as partners in planning services for children.

Objective I:	Involving Parents As Partners	1. Understand why parent involvement is important for setting functional goals/objectives. 2. Recognize why and how parent involvement can vary. 3. Use strategies for involving parents as partners in program planning. 4. Plan how parent information will be shared with other staff.

GOALS AND OBJECTIVES FOR UNIT V
FEDERAL/STATE REGULATIONS

GOAL: Participants will increase their knowledge of, and ability to comply with, Federal and State Regulations related to the provision of day-care services for children 0-5 with disabilities.

Objective I	State and Local Regulations for Day Care	1. Be familiar with state/local regulations governing day care. 2. Maintain accurate records related to child/family services required by law.
Objective II	Federal and State Guidelines for Early Childhood Services for children with Disabilities	1. Be familiar with the requirements of PL95-602, PL-94-142, and PL99-457. 2. Develop a written policy statement supporting the principles of normalization, early intervention, and least restrictive environment.

Inservice Presentation Format

Project Lexington
Inservice Presentation Format

Date: **Time:** **Topic:**

Time	Topic/Objective	Presenter(s)	Lecture Content [Limit 15 min.]	Small Group Activity	Materials/ Handouts

NOTE:

Inservice Evaluation Forms

SAMPLE

August - October 1990

Project Lexington Inservice Training Program

Inservice Evaluation for August 18, 1990

How helpful was today's inservice training program....

We would appreciate you taking a few minutes to fill out this evaluation form to let Project Lexington staff know how today's inservice has helped meet your training needs. Please fill in answers to all of the questions, so that we can use your suggestions to improve the inservice training program. Thank you for your assistance.

Please use the following 5 point scale to rate items 1 - 8.

1	2	3	4	5
Not At All Helpful	Of Little Help	Somewhat Helpful	Of Great Help	Extremely Helpful

Unit I: Trends In Early Childhood Special Education

Learning objectives .....

1. Acknowledge personal attitudes toward children with disabilities. ---1---2---3---4---5---
2. Understand the implications of having a disability for community participation. ---1---2---3---4---5---
3. Recognize myths about developmental disabilities. ---1---2---3---4---5---
4. Be aware of service trends related to young children with disabilities. ---1---2---3---4---5---
5. Identify major components of the Developmental Disabilities Act. ---1---2---3---4---5---
6. Identify major components of related early childhood legislation. ---1---2---3---4---5---
7. Understand terminology used by service providers working with children with disabilities. ---1---2---3---4---5---
8. Recognize general categories, characteristics, and early childhood strategies for working with children with disabilities. ---1---2---3---4---5---

(Over)

What can we do to make the inservice program more helpful ......

Please answer the following questions as completely and honestly as you can. Your answers will help us to make future inservice programs more helpful.

---

9. Please describe the components of the training program that you found most helpful (i.e. specific topics, lecture material, overheads, small group activities, etc.).

10. Please describe the components of the training program that you found least helpful.

11. Please give us your suggestions for making the training program more helpful.

PROJECT LEXINGTON INSERVICE PROGRAM
TECHNICAL ASSISTANCE FORMS

- Technical Assistance Consultant Guidelines
- Technical Assistance Objectives Worksheet
- Summary of Staff Priority Technical Assistance
- Follow-up Observation and Technical Assistance Record
- Technical Assistance Consultant Recording Forms

Technical Assistance Consultant Guidelines

Project Lexington Technical Assistance Consultant Guidelines

- The purpose of Project Lexington Technical Assistance is to assist participants to apply the information and techniques learned during the training sessions within their own child care setting.

- Each participant is eligible to receive a total of 6 hours of technical assistance.

- Each consultant may be providing some portion of this total technical assistance.

- Each consultant should begin the TA process by scheduling at least 1/2 hour with participants in their small group, to identify individualized TA plans [see attached worksheet].

- Up to two hours of each participant's technical assistance may be provided in a small group setting, if applicable to the TA objective.

- Up to 1 hour per participant may be allocated for compilation and review of materials to meet the participant's need for information.

- At least 3 hours per participant must be spent in one-to-one skill development, including assistance within the classroom setting. In the case of TA to administrative staff, this direct facilitation of skill development may be used to develop policy and procedures which will be implemented for the child care program.

- Each TA session should include assignments to be carried out by individual participants between meetings.

- Consultants must keep written records or summaries of TA provided, which include evaluative information derived from the TA objective outcomes on the TA Objectives Worksheet.

- The reimbursement for consultation shall be $20.00 per hour, per participant. The total consultation hours will be determined by the Project Lexington Director. A reimbursement form will be completed by the consultant which specifies the total consultant hours and signed by the consultant and Director.

Technical Assistance Objectives Worksheet

Project Lexington Technical Assistance Objectives Worksheet

Consultant Name: ________Date:___
Consultee Name : ________Date:___

What the Consultant Will Do:	What the Consultee Will Do*:	Conditions for Achieving the Objective:	Target Criteria and Date for Achieving the Objective:

* Complete this column first, by identifying the outcome objective for TA.

Example:

Given .5 hrs. training & two.5 hrs.... supervision...	Becky will be able to complete and interpret an ABC assessment...	without observer bias, & with a working instructional plan...	for children with disruptive behavior, by 3/14/91.

Summary of Staff Priority Technical Assistance

Staff Priority Areas For Project Lexington Technical Assistance

Date

Center Name:

Summary of Administrative Priorities for Technical Assistance

Summary of Staff Priority For Follow-up Technical Assistance

SKILL AREAS	NAME OF STAFF							
Child Care Environment								
1. Adapt settings, materials, and equipment to assure access to all children, including children with disabilities.								
2. Promote positive self-concept by providing children with ongoing opportunities for independence, making choices, initiating activities, and imitation.								
3. Reflect mutual respect by using methods of positive negotiation, active listening, and shared problem solving.								
4. Modify the physical setting to encourage positive interactions between children.								
5. Attain instruction in how to properly use medications and/or assistive devices needed by individual children from licensed health care providers or therapists.								
6. Conduct regular center safety checks using a checklist for center safety, which is based on the needs of individual children.								
Working With Parents								
7. Recognize, and try to accommodate, the complex schedules of families of children with disabilities.								
8. Avoid service replication between our center services and those provided by other agencies working with families or children.								

9. Implement transition plans between services which are designed to: a) build on family strengths, b) assist families to coordinate their own children's services, and c) support families in accomplishing their goals.								
10. Involve parents in taking active roles in assessment and program planning for their children.								
11. Regularly involve parents in identifying functional goals and objectives for their children by using parent inventories to assess children's daily routines in home and community settings.								
12. Share parent information with other staff members for purposes of program/curriculum planning, during regularly scheduled staff meetings.								
13. Encourage and promote parent decision making and planning for their children's special service needs.								
14. Provide formal or informal parent education regarding parent/child relationships, transition planning, and service coordination.								
15. Identify family strengths, and build on these strengths to assist families to meet their needs.								
Coordination of Assessment and Program Planning								
16. Use effective team process skills to maintain positive working relationships with parents, professionals and children.								

17. Maintain communication between the center staff and team members involved in the IFSP/IEP process.								
18. Use formal and informal observation techniques to evaluate child development progress.								
19. Choose and administer appropriate developmental assessment instruments.								
20. Interpret and integrate recommendations of therapeutic staff involved with IFSP/IEP assessments within center based individual program planning.								
21. Write functional goals and objectives for each developmental area for which assessment has indicated a need for improvement.								
Planning and Implementing Curriculum								
22. Select age-appropriate activities which reflect the child's family and cultural setting.								
23. Embed basic skill training in real, functional, normal, age-appropriate activities (Example: learning center or field trip experiences which happen to include counting activities).								
24. Use planned strategies to increase the type and degree of interaction among children with disabilities and nondisabled children.								
25. Use a reliable method to identify childrens' level of attaining adaptive "survival" skills, which will be needed to function in current and future academic and social settings.								

26. Develop curriculum objectives and activities to include adaptive skills, and use cues and corrective procedures that will be used in future community settings.								
Ensuring Compliance With Regulations								
27. Maintain accurate records and files pertaining to child/family service delivery, required by law.								
28. Describe the importance of public law early regulations for children with disabilities, and the implications for children served in integrated child care settings.								
29. Develop written policy statement(s) describing center program and philosophy supporting the principles of normalization, early intervention, and least restrictive environment.								
Additional TA Requests								

Technical Assistance Notes:

Follow-up Observation and Technical Assistance Record

Project Lexington
Follow-up Observation and Technical Assistance Record

1989-1990 Session Participants:

Name	ID#	Obser. Dates			Technical Assistance Date/Hrs					
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
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					-	-	-	-	-	-

Project Lexington Technical Assistance Consultant Recording Forms

Project Lexington Technical Assistance

Objective: 1. **Adapt settings, materials, and equipment to assure access to all children, including children with disabilities.**

Date:__________________________ Location:_____________________

Time: From __________ to __________.

Technical Assistance Provided To:

____

Technical Assistance Provided By:

____

Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 2. Promote positive self-concept by providing children with ongoing opportunities for independence, making choices, initiating activities, and imitation.

Date:________________________ Location:____________________

Time: From _________ to _________.

Technical Assistance Provided To:

Technical Assistance Provided By:

Technical Assistance Summary:

Comments/Observations:

Project Lexington Technical Assistance

Objective: **3. Reflect mutual respect by using methods of positive negotiation, active listening, and shared problem solving.**

Date:________________________ Location:____________________

Time: From __________ to __________.

Technical Assistance Provided To:

____

Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: **4. Modify the physical setting to encourage positive interactions between children.**

Date:________________________ Location:____________________

Time: From __________ to __________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 5. Attain instruction in how to properly use medications and/or assistive devices needed by individual children from licensed health care providers or therapists.

Date:________________________ Location:____________________

Time: From _________ to _________.

Technical Assistance Provided To:

____

Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 6. Conduct regular center safety checks using a checklist for center safety, which is based on the needs of individual children.

Date:________________________ Location:____________________

Time: From __________ to __________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: **7. Recognize, and try to accommodate, the complex schedules of families of children with disabilities.**

Date:__________________________ Location:_____________________

Time: From __________ to __________.

Technical Assistance Provided To:

Technical Assistance Provided By:

Technical Assistance Summary:

Comments/Observations:

Project Lexington Technical Assistance

Objective: 8. Avoid service replication between our center services and those provided by other agencies working with families or children.

Date:_________________________ Location:____________________

Time: From __________ to __________.

Technical Assistance Provided To:

____

Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 9. Implement transition plans between services which are designed to: a) build on family strengths, b) assist families to coordinate their own children's services, and c) support families in accomplishing their goals.

Date:________________________ Location:____________________

Time: From __________ to __________.

Technical Assistance Provided To:

____

Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: **10. Involve parents in taking active roles in assessment and program planning for their children.**

Date:__________________________ Location:_____________________

Time: From __________ to __________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 11. Regularly involve parents in identifying functional goals and objectives for their children by using parent inventories to assess children's daily routines in home and community settings.

Date:____________________________ Location:____________________

Time: From __________ to __________.

Technical Assistance Provided To:

____

Technical Assistance Provided By:

____

Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 12. Share parent information with other staff members for purposes of program/curriculum planning, during regularly scheduled staff meetings.

Date:________________________ Location:__________________

Time: From _________ to _________.

Technical Assistance Provided To:

Technical Assistance Provided By:

Technical Assistance Summary:

Comments/Observations:

Project Lexington Technical Assistance

Objective: 13. Encourage and promote parent decision making and planning for their children's special service needs.

Date:__________________________ Location:_____________________

Time: From __________ to __________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 14. Provide formal or informal parent education regarding parent/child relationships, transition planning, and service coordination.

Date:_________________________ Location:____________________

Time: From _________ to _________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 15. Identify family strengths, and build on these strengths to assist families to meet their needs.

Date:__________________________ Location:_____________________

Time: From __________ to __________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 16. Use effective team process skills to maintain positive working relationships with parents, professionals and children.

Date:________________________ Location:____________________

Time: From __________ to __________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 17. Maintain communication between the center staff and team members involved in the IFSP/IEP process.

Date:________________________ Location:____________________

Time: From _________ to _________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: **18. Use formal and informal observation techniques to evaluate child development progress.**

Date:________________________ Location:___________________

Time: From _________ to _________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Objective: **19. Choose and administer appropriate developmental assessment instruments.**

Date:________________________ Location:___________________

Time: From _________ to _________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 20. Interpret and integrate recommendations of therapeutic staff involved with IFSP/IEP assessments within center based individual program planning.

Date:________________________ Location:____________________

Time: From __________ to __________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 21. Write functional goals and objectives for each developmental area for which assessment has indicated a need for improvement.

Date:__________________________ Location:_____________________

Time: From __________ to __________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 22. Select age-appropriate activities which reflect the child's family and cultural setting.

Date:__________________________ Location:_____________________

Time: From __________ to __________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 23. Embed basic skill training in real, functional, normal, age-appropriate activities (Example: learning center or field trip experiences which happen to include counting activities).

Date:_________________________ Location:____________________

Time: From _________ to _________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 24. Use planned strategies to increase the type and degree of interaction among children with disabilities and nondisabled children.

Date:__________________________ Location:_____________________

Time: From __________ to __________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 25. Use a reliable method to identify childrens' level of attaining adaptive "survival" skills, which will be needed to function in current and future academic and social settings.

Date:________________________ Location:____________________

Time: From _________ to _________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 26. Develop curriculum objectives and activities to include adaptive skills, and use cues and corrective procedures that will be used in future community settings.

Date:________________________ Location:____________________

Time: From _________ to _________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: 27. Maintain accurate records and files pertaining to child/family service delivery, required by law.

Date:________________________ Location:____________________

Time: From __________ to __________.

Technical Assistance Provided To:

Technical Assistance Provided By:

Technical Assistance Summary:

Comments/Observations:

Project Lexington Technical Assistance

Objective: 28. Describe the importance of public law early regulations for children with disabilities, and the implications for children served in integrated child care settings.

Date:________________________ Location:____________________

Time: From __________ to __________.

Technical Assistance Provided To:

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Technical Assistance Provided By:

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Technical Assistance Summary:

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Comments/Observations:

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Project Lexington Technical Assistance

Objective: **29. Develop written policy statement(s) describing center program and philosophy supporting the principles of normalization, early intervention, and least restrictive environment.**

Date:________________________ Location:____________________

Time: From __________ to __________.

Technical Assistance Provided To:

Technical Assistance Provided By:

Technical Assistance Summary:

Comments/Observations:

PROJECT LEXINGTON INSERVICE PROGRAM EVALUATION FORMS

- Early Childhood Program Profile
- Participant Pre/post Inservice Evaluation Scale
- Child Care Program Observation Form

Early Childhood Program Profile

EARLY CHILDHOOD PROGRAM PROFILE

1. Date: ________________

2. Name of Center_______________________________________
Address____
________________________________Phone______________

3. Your position/title____________________________________

4. Check which one best represents your program:

____Private, non-profit
____Private, for-profit
____Publicly funded
____Head Start
____Church affiliated
____College/University affiliated
____Corporate affiliated
____Other: ____________________

5. How many weeks of the year does your program operate?

____

6. Check the following additional care that you provide.

____Evening
____Weekend
____Respite
____Overnight

9. Number of children for which your center is licensed_________

10. Ages of children enrolled in your program________to_________

11. Number of children currently enrolled in your program_______

12. Number of vacancies in your program ______________

13. Current number of children in your program

____Infants (birth - 12 mo.)
____Toddlers (13-24 mos.)
____Preschool (3-5 yrs.)
____School Age (6-12 yrs.)

14. Possible full enrollment numbers

____Infants
____Toddlers
____Preschool
____School-Age

15. Does your program provide transportation for children?

____Yes ____No

16. Is the transportation provided handicap accessible?

____Yes ____No

17. Indicate the NUMBER of paid staff in your program with education at the following levels.

Teachers	Assistant Teachers	Administrators	
____	____	____	Less than high school diploma or GED
____	____	____	High School diploma or GED
____	____	____	Post secondary; vocational; AA; some college
____	____	____	Bachelor's degree
____	____	____	Some graduate credits
____	____	____	Master's degree
____	____	____	Doctoral degree

18. Indicate the NUMBER of paid staff in your program that have the following training in the following areas. (ECE - Early Childhood Education, CD - Child Development)

Teachers	Assistant Teachers	Administrators	
____	____	____	1-6 hours ECE/CD
____	____	____	7-12 hours ECE/CD
____	____	____	Post secondary: vocational: AA; some college in ECE/CD
____	____	____	Post Secondary vocational; AA; some college in related field
____	____	____	Post Secondary vocational; AA; some college in non-related
____	____	____	Bachelor's in ECE/CD
____	____	____	Bachelor's in related field
____	____	____	Bachelor's in Special Education
____	____	____	Bachelor's in non-related field
____	____	____	Master's in ECE/CD
____	____	____	Master's in related field
____	____	____	Master's in Special Education
____	____	____	Master's in non-

related field

19. Indicate the NUMBER of paid staff that have the following years of experience in the field.

Teachers	Assistant Teachers	Administrators	
____	____	____	Less than one year
____	____	____	2 - 5 years
____	____	____	6 - 10 years
____	____	____	11 years and more

20. Indicate the NUMBER of paid staff that have worked in your program for the following periods of time.

Teachers	Assistant Teachers	Administrators	
____	____	____	Less than one year
____	____	____	2 - 5 years
____	____	____	6 - 10 years
____	____	____	11 years and more

21. Indicate the NUMBER of paid staff that have worked with children with disabilities

Teachers	Assistant Teachers	Administrators
____	____	_____

22. How many classrooms are there for each of the following?

____Infants (birth - 12 mos.)
____Toddlers (13-24 mos.)
____Preschool (3-5 yrs.)
____School Age (6-12 yrs.)

23. What is your paid staff child ratio in the following classrooms?

____Infants (birth - 12 mos.)
____Toddlers (13-24 mos.)
____Preschool (3-5 yrs.)
____School-Age (6-12 yrs.)

24. Check any other sources of staff used:

____Senior Citizen Volunteers
____High school/university students
____Others

25. Does the use of volunteers change your Daily staff/child ratio?

____Yes ____No

If so, how?

____Infants (birth - 12 mos.)
____Toddlers (13-24 mos.)
____Preschool (3-5 yrs.)
____School-Age (6-12 yrs.)

26. List all the agencies from which you receive volunteers, high school/university students, etc.

____
____
____
____
____

27. Is your program accredited by the National Association for the Education of Young Children? ____Yes ____No

28. List any other organizations by which your program is accredited.

____

____

29. Does your program have a policy on serving children with handicaps/disabilities?*

____Yes ____No

If Yes, please describe that policy______________________

____

____

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____

30. Does your program currently serve children with disabilities?

____Yes ____No

31. If you do not currently serve children with disabilities, do you have plans to do so in the future? ____Yes ____No.

32. What are the major reasons that your program does not serve children with disabilities?

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*NOTE: Various terms are used to describe children who have been identified to have a physical or mental developmental disability - "handicapped", "special needs", etc. The term "disabilities" will be used throughout to designate this broad group of children.

33. If your program does serve children with disabilities, are the children served in the regular classroom (mainstreamed)?

____Yes ____No

34. If you are mainstreaming children, what is the ratio of children with disabilities to typical children in the following classrooms?

____with disabilities ____non-disabled

35. If you do serve children with disabilities, list the number of children you are currently serving with the following conditions:

____Developmental Delay

____Mild Mental Retardation

____Moderate Mental Retardation

____Severe/profound Mental Retardation

____Orthopedic Handicaps

____Speech Impaired

____Language/Communication Impaired

____Visually Impaired & Blind

____Hearing Impaired & Deaf

____Autistic or Autistic Like

____Multiply Handicapped

36. List all the assessment tools that you use to identify children's developmental level.

37. Describe how you select children to enroll to fill vacancies in your program.

38. How do you recruit children for your program?

39. If your program serves children with disabilities, how do you recruit these children for your program?

40. If your program serves children with disabilities, list the agencies with which you work to recruit these children.

41. What indoor classroom equipment has your program purchased for the purpose of mainstreaming children with disabilities.

42. What outdoor equipment has your program purchased for the purpose of mainstreaming children with disabilities?

43. What adaptations to your physical facility have you made to serve children with disabilities?

44. Does your program have staff meetings?

____Yes ____No

45. How often does your program have staff meetings?

____Once a Week
____Once Every Two Weeks
____Once a Month
____Once Every Two Months
____Other

46. Does your program provide staff training/development?

____Yes ____No

47. How is it determined what will be presented in the staff training/development?

48. List all the community and support agencies with which your program works.

49. Does your program have a parent education/involvement component? ____Yes ____No

50. If your program does have a parent education involvement component, list the various ways that parents may participate in your program.

PLEASE ENCLOSE A COPY OF YOUR PARENT HANDBOOK POLICY MANUAL, JOB DESCRIPTIONS, AND ANY OTHER MATERIALS THAT MIGHT BE USEFUL FOR US TO UNDERSTAND YOUR COMPLETE PROGRAM. THANKS!

Participant Pre/post Inservice Evaluation Scale

Participant Number ______
(last 4 digits of Social Security number)

PROJECT LEXINGTON

Participant Questionnaire

Please fill out the following questionnaire as honestly and completely as you can. It should take about 20 minutes to complete. Some sections have directions explaining the procedure for completion, read them carefully. Please complete EVERY item with the best possible answer. Thank you for your cooperation.

Please circle the letters in the row that best describes your agreement or disagreement with the following statements. There are no correct answers; the best answers are those that honestly reflect your feelings.

Scale:
SA = Strongly Agree
A = Agree
U = Undecided
D = Disagree
SD = Strongly Disagree

1. Many of the things teachers do with regular students in a classroom are appropriate for special-needs students. SA A U D SD
2. The needs of handicapped students can best be served through special, separate classes. SA A U D SD
3. A special-needs classroom behavior generally requires more patience from the teacher than does the behavior of a normal child. SA A U D SD
4. The challenge of being in a regular classroom will promote the academic growth of the special-needs child. SA A U D SD
5. The extra attention special-needs students require will be to the detriment of the other students. SA A U D SD
6. Mainstreaming offers mixed group interaction which will foster understanding and acceptance of differences. SA A U D SD
7. It is difficult to maintain order in a regular classroom that contains a special-needs child. SA A U D SD

Source: Attitude questions # 1-30 from: Larrivee, B. & Cook, L. (1979). Mainstreaming: A study of the variables affecting teacher attitudes; The Journal of Special Education, Vol 3. 315-324.

8. Regular teachers possess a great deal of the expertise necessary to work with special-needs students. SA A U D SD

9. The behavior of special-needs students will set a bad example for the other students. SA A U D SD

10. Isolation in a special class has a negative effect on the social and emotional development of a special-needs student. SA A U D SD

11. The special-needs child will probably develop academic skills more rapidly in a special classroom than in a regular classroom. SA A U D SD

12. Most special-needs children do not make an adequate attempt to complete their assignments. SA A U D SD

13. Integration of special-needs children will require significant changes in regular classroom procedures. SA A U D SD

14. Most special-needs children are well behaved in the classroom. SA A U D SD

15. The contact regular-class students have with mainstreamed students may be harmful. SA A U D SD

16. Regular-classroom teachers have sufficient training to teach children with special needs. SA A U D SD

17. Special-needs students will monopolize the teacher's time. SA A U D SD

18. Mainstreaming the special-needs child will promote his/her social independence. SA A U D SD

19. It is likely that a special-needs child will exhibit behavior problems in a regular classroom setting. SA A U D SD

20. Diagnostic-prescriptive teaching is better done by resource-room or special teachers than by regular-classroom teachers. SA A U D SD

21. The integration of special-needs students can be beneficial for regular students. SA A U D SD

22. Special-needs children need to be told exactly what to do and how to do it. SA A U D SD

23. Mainstreaming is likely to have a negative effect of the emotional development of the special-needs child. SA A U D SD

24. Increased freedom in the classroom created too much confusion. SA A U D SD

25. The special-needs child will be socially isolated by regular classroom students. SA A U D SD

26. Parents of a special-needs child present no greater problem for a classroom teacher than those of a normal child. SA A U D SD

27. Integration of special-needs children will necessitate extensive retraining of regular teachers. SA A U D SD

28. Special-needs students should be given every opportunity to function in the regular-classroom setting, where possible. SA A U D SD

29. Special-needs children are likely to create confusion in the regular classroom. SA A U D SD

30. The presence of special-needs students will promotes acceptance of differences on the part of regular students. SA A U D SD

Please answer all questions by circling or checking the correct answer.

1. True or False: Providing opportunities for a person to grow and develop is characteristic of the developmental model.

2. True or False: Behavior management techniques are put into operation before the children enter the classroom.

3. True or False: A learning disability is a type of neurological impairment.

4. True or False: In most instances of mental retardation, the cause can be established.

5. True or False: A physical disability refers to impaired motor function, and may be caused by a variety of medical or structural conditions including: arthritis, cerebral palsy, muscular dystrophy, spina bifida, or spinal chord

damage.

6. True or False: Mental retardation is defined as a significant subaverage intellectual functioning, existing concurrently with deficits in adaptive behavior.

7. True or False: Learning disabilities occur in individuals of subaverage intelligence who experience a disorder in understanding or processing language.

8. True of False: Labels tell you most of what you need to know about a person with disabilities.

9. True or False: Normalization requires eliminating segregation.

10. The belief that, under the proper conditions every individual is capable of learning and developing, regardless of age or level of disability, is referred to as:
    _____normalization
    _____the developmental model
    _____civil rights
    _____rehabilitation

11. When making physical adaptations to the classroom environment and/or equipment to integrate a disabled child you could ask for help from:
    _____physical therapist
    _____occupational therapist
    _____Both A & B
    _____None of the above.

12. Which of the following would assist you and a disabled child in developing alternative modes of communication?
    _____audiologist
    _____speech/language specialist
    _____tone therapist
    _____audio/visual therapist

13. The _____ licenses child-care facilities in the State of Kentucky.
    _____Department of Social Services
    _____Department of Education
    _____Health Department
    _____Division of Licensing and Regulation

14. In order to determine what kinds of services are needed by a person with disabilities, you must:
    _____Assess strengths and needs.
    _____Know into which category a person fits.
    _____Assess strengths, needs and know what category in which the person fits.

15. A child care provider's license in Kentucky is valid for:

_____one year
_____two years
_____three years
_____five years

16. List four ways in which an integrated child care setting can facilitate children's coping, socialization, self-esteem and self-confidence.

17. List three generic services that can be used to meet the needs of individuals with disabilities.

18. List three local agencies with which you might work when providing services to a disabled child in your integrated classroom.

19. List four ways to ensure peer interactions among children having varied developmental levels.

20. List the steps used in writing functional goals and objectives.

21. What is an IFSP?

22. Who might be members of an IFSP team?

23. List two reasons why parents should be involved in making

choices and decisions about their children's lives.

24. Describe the least restrictive environment.

25. Public Laws 95-602, 94-142, and 99-457 mandate what?

Child Care Program
Observation Form

Subject number__________

OBSERVATION FORM

1. Date of Observation______________________________

2. Age range of children in group______________________________

3. Group size______________________________

4. Staff/child ratio______________________________

5. Is there a child with a disability enrolled in this class?
_____Yes _____No

Comment/Interview______________________________

6. What is (are) the handicapping condition(s) in the classroom.
____

JOB FUNCTION I

7. Adapt settings to assure access for all children.

Typical Children

Yes	No	Did Not Observe

Comment/Interview______________________________

____

____

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview______________________________

____

____

8. Adapt materials to assure access for all children.

Typical Children

Yes	No	Did Not Observe

Comment/Interview____

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview____

9. Promote positive self-concept through providing opportunities to make choices.

Typical Children

Yes	No	Did Not Observe

Comment/Interview____

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview____

10. Promote positive self-concept through providing opportunities to initiate activities.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

11. Promote positive self-concept through providing opportunities to imitate.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

12. Reflect mutual respect by using methods of positive negotiation.

Typical Children

Yes	No	Did Not Observe

Comment/Interview____

____

____

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview____

____

____

13. Reflect mutual respect by using active listening.

Typical Children

Yes	No	Did Not Observe

Comment/Interview____

____

____

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview____

____

____

14. Reflect mutual respect by using shared problem solving.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

15. Implements proper use of medications.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

16. Establishes regular center safety checklist.

Typical Children

Yes	No	Did Not Observe

Comment/Interview ____________________

____

____

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview ____________________

____

____

17. Conducts regular center safety checks.

Typical Children

Yes	No	Did Not Observe

Comment/Interview ____________________

____

____

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview ____________________

____

____

18. Accommodates complex schedules of families.

Typical Children

Yes	No	Did Not Observe

Comment/Interview____

____

____

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview____

____

____

19. Implements transition plans to build family strengths.

Typical Children

Yes	No	Did Not Observe

Comment/Interview____

____

____

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview____

____

____

20. Parents are involved as team members, taking active roles in assessment and program planning.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

21. Share parent information with other staff members.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

22. Identify family strengths and build on these strengths to meet family needs.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

23. Use effective team process skills to maintain positive working relationship with parents.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

24. Use effective team process skills to maintain positive working relationship with parents.

Typical Children

Yes	No	Did Not Observe

Comment/Interview______________________________

____

____

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview______________________________

____

____

25. Use of formal and informal observation techniques to evaluate child development progress.

Typical Children

Yes	No	Did Not Observe

Comment/Interview______________________________

____

____

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview______________________________

____

____

26. Used appropriate developmental assessment instruments.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

27. Writes functional goals and objectives for each developmental area for which assessment has indicated a need for improvement.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

28. Selects age-appropriate activities that reflect the child's cultural setting.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

29. Maintain accurate records and files pertaining to service delivery.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

30. Develop written policy statement describing center program and philosophy supporting the principles of normalization, early intervention and least restrictive environment.

Typical Children

Yes	No	Did Not Observe

Comment/Interview

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

SPECIALIZED JOB RESPONSIBILITY

31. Adapt equipment to assure access for all children.

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview

32. Promote positive self-concept through opportunities for independence.

Children with a Disability		
Yes	No	Did Not Observe

Comment/Interview

33. Modify the physical setting to encourage positive interactions.

Children with a Disability		
Yes	No	Did Not Observe

Comment/Interview

34. Implements proper use of assistive devices.

Children with a Disability		
Yes	No	Did Not Observe

Comment/Interview

35. Avoids service duplication between service agencies.

Children with a Disability		
Yes	No	Did Not Observe

Comment/Interview ______________________________

____

____

36. Assists families to coordinate children's services.

Children with a Disability		
Yes	No	Did Not Observe

Comment/Interview ______________________________

____

____

37. Encourage and promote parent decision making and planning for their children's special service needs.

Children with a Disability		
Yes	No	Did Not Observe

Comment/Interview ______________________________

____

____

38. Use effective team process skills to maintain positive working relationships with professionals.

Children with a Disability		
Yes	No	Did Not Observe

Comment/Interview

39. Maintain communication between the center staff and team members involved in the IEP/IFSP process.

Children with a Disability		
Yes	No	Did Not Observe

Comment/Interview

40. Integrate therapeutic staff recommendations within center based IEP/IFSP.

Children with a Disability		
Yes	No	Did Not Observe

Comment/Interview

41. Increases the type and degree of interaction among children with disabilities and typical children.

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview____

____

____

42. Identify adaptive "survival" skills to function in current, future and social situations.

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview____

____

____

43. Develop curriculum activities to include adaptive skills.

Children with a Disability

Yes	No	Did Not Observe

Comment/Interview____

____

____

Project Lexington Inservice Training

Content Summary:

Expanding Community Child Care Options for Children With Special Needs

Interdisciplinary Human Development Institute
University Affiliated Program
University of Kentucky

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UNIT I: TRENDS IN INTEGRATED EARLY CHILDHOOD SPECIAL EDUCATION

I. Exploring Values Attitudes and Services

A. Acknowledging Personal Attitudes and Values - As early childhood educators, how well we work with children with disabilities and their families will, to a large degree, depend on our own attitudes and values. To the extent that we value diversity, we are likely to work well with children from diverse backgrounds and with differing abilities. Our own beliefs, however, have been influenced by our experiences within our families, society, and culture. Likewise, our work with children and families reflects our prior early childhood education training, and the philosophy of our early childhood programs.

Culture can be defined as, "the collection of principles, beliefs, norms, rules, and expected behaviors that govern the organization of that society" (Schiamberg, 1988). How a culture defines what is "important" to its people will be reflected in the myths, values, attitudes and services that are passed between generations. Historically, the values and attitudes that a society has held about people with disabilities has a direct relationship to what services are provided, for whom, in what setting, and at what cost. It is important to remember that:

- what a society believes in, and how these beliefs are translated into public policy;
- what an agency believes in, and how these beliefs are translated into policies, procedures, and services; and
- what individual staff members believe in, and how these beliefs translate into interpersonal relationships with the people they serve,

all work together to impact the quality of life of people with disabilities (Middendorf, 1988).

The component parts of a culture change with time. Various economic, political, or environmental changes can result in new sets of social values, attitudes, myths, and services being adopted. New social patterns for designing or defining traditional institutions such as "schools" and "family" often emerge. Along with influencing our general social attitudes and practices, our culture and related social trends influence our definition of "disability" as well as how we will respond to people with disability

- labels limit our ability to recognize a person's strengths by focussing on their weaknesses;
- labels limit what we expect a person to achieve;
- service systems reflect the limitations imposed by labels and don't always provide opportunities to maximize a person's potential; and
- labels depersonalize, creating situations where we accept a quality of life for others that we would never tolerate for ourselves (Middendorf, 1987).

While the traditional categorical service system and practice of labeling have highlighted the deficiencies of people with disabilities, people with disabilities do not concentrate on their limitations. Rather, just like all of us, people with disabilities define their lives in terms of accomplishments, relationships, hopes, dreams, and aspirations. From our personal agenda each of us choose what neighborhoods we will live in, what recreational activities we enjoy, what professionals we want to see for medical or other advise, what kind of jobs we want to have, and with whom we spend our leisure time. For people with disabilities, these normal, everyday choices are sometimes limited by social definition and practice. As a consequence of categorical service delivery and labeling, people with disabilities are often handicapped by a lack of accessibility to community options.

II. Trends in Services to Children With Disabilities

A. Myths About Children With Developmental Disabilities - Myths about children with mental retardation or other disabilities, which have been reflected in mainstream culture within the United States include that:

- these children are delicate or vulnerable and therefore need to be protected or sheltered;
- these children cannot develop the skills necessary to participate in mainstream society; and
- these children may develop undesirable characteristics that threaten other people within the community.

The roots of these myths become clear as we review the history of cultural beliefs and service trends active in western society. Largely through years of experience and research focusing on human development, these myths have proven to be invalid. We now know that all children learn and develop, and generally benefit, from *inclusion* rather than *exclusion* from the mainstream of society.

(Anderson, 1989). An excellent book discussing the cultural context of early intervention is: . Lynch, E.W. & Hanson, M.J. (1992). Developing cross-cultural competence: A guide for working with young children and their families. Baltimore: Paul H. Brookes Publishing Company.

Appendix A, includes an outline of some of the perceptions and consequences of social attitudes about people with developmental disabilities, concluding with the perception of the person as a developing citizen, attitudes currently being supported by federal, state, and local legislation and policy development.

B. Implications of Labeling For Participation in Community Settings - For years people with disabilities have been identified according to diagnostic, or categorical labels. Mental retardation, cerebral palsy, deaf, blind, severe and profound, emotionally disturbed -- are all terms used within the service system to distinguish groups of people according to "service needs." Our society has developed a service system that parallels this approach. We have designed specialized service programs for people with mental retardation, for people who are deaf or hearing impaired, for people who are mentally ill, and so forth. The result of this method of service delivery is that people have been defined and grouped according to their inabilities. Often specialized services have been (and still are) provided in segregated settings. In turn, negative social stereotypes have developed around these labels, which ignore the broad range of ability and personal value of any one individual, and promote social stigma.

No matter what type of label is used, just knowing that a person has a developmental disability tells us very little about the person. The label does not tell us whether the person can walk or talk, the style of the person's communication, his or her likes and dislikes, if he or she is sociable, moody, or aggressive, or if he or she has a good sense of humor. We can only get to know these things about people by spending time getting to know them -- through personal relationships. As individuals, we may have come to fear people with disabilities. In general, this is because the categorical service delivery system has structurally prevented most of us from having opportunities to develop meaningful relationships with people having a disability.

Labeling has additional implications for both service delivery and public acceptance. Some of the negative implications of labeling people include:

B. Trends in Children's Services: A Cultural/Historical Perspective - While the field of early childhood special education is relatively new, the concept of attending to young children's individual and unique developmental needs has a long history. In the minds of early childhood advocates of the 18th, 19th, and 20th centuries all children were special. Unfortunately, over much of this history, these innovative attitudes were in stark contrast to the realities of contemporary social practice.

To gain a better understanding of the trends in services for children with developmental disabilities, it is helpful to have some knowledge of the cultural and historical perspectives that have influenced these trends. This section reviews cultural/historical perspectives regarding: (a) family structure, (b) service to people with disabilities, and (c) early childhood education.

Family Structure:

Based on the work of Howard (1984), the social reality of the 16th and 17th century was that slightly more than half of all children lived to be adults. In general, families were thought of as political or social units, rather than as centers for intimacy or child rearing. Practices of infanticide, aggression, abandonment, and sexual exploitation of children were common and generally culturally accepted over much of this period. During the 18th century, as "peasants" moved into towns seeking work, children worked along with their parents for long hours, under harsh conditions, receiving little if any wage. According to Howard, it was not uncommon for children to be maimed, in order to become better beggars. For shop-keeping families life was somewhat kinder. Early-on shops were in the home, with children learning the skills of their parents. By the late 1700's, shops were becoming separated from the home and, for the first time in history, domestic responsibility became a primary role for mothers. The nuclear family had been conceived, marriage was forever, husbands worked in their businesses, and mothers took care of their children at home. During this time, mothers were considered responsible for their children's souls, and child-rearing became a blend of attention and tenderness during infancy, and strict discipline and rigid schedules during childhood. During the 1800's, the nuclear family was becoming the accepted standard within Europe and America. By the 1830's, however, Howard reports that early feminists were beginning to challenge the segregation of men's recreational clubs and lodges, which excluded women, and pressuring their husbands to spend more time at home with the family. Thus, for the first time in history, the role of "father" began to emerge as a value in western culture.

Today, during the 20th century, we have experienced yet another "revolution" in our cultural definition of family. The nuclear family is rapidly being replaced by "diversity of family structure" as an accepted cultural norm. Today, as many as one-in-five children experience some period of their childhood in a single-parent home. More than 60% of mothers with children under age 14 are in the labor force, and 50% of mothers are returning to work before their child's first birthday (Wallis, 1987). In 1990, it is estimated that 13.3 million preschoolers have mothers in the work force, an increase of 58% from 1980 (Hofferth, 1979).

Services To People With Disabilities:

A historic review of trends in services to people with disabilities (Middendorf, 1987) reveals how medical and social attitudes affect direct service delivery.

Given the high mortality rate, lack of knowledge regarding human development, and challenging living conditions of the 17th and 18th centuries, it is not surprising that little consideration was given to people with disabilities. During the 1700's, as many as 80% of the people in prisons and so-called "poor houses" had some type of disability. The early 1800's brought the first empathic attempts to understand and respond to the needs of people with disabilities. The "nurturing/caretaking role," brought into vogue by the shop-keeping families of the 1700's, was beginning to take on broader social significance related to services for people with disabilities.

As early as 1800, Jean Marc Itard worked with a boy who had been totally isolated from human contact from birth to age twelve. Victor, "the wild-boy of Aveyron", was considered to be permanently and severely retarded. Itard succeeded in teaching Victor to recognize objects by name, to identify parts of the alphabet, to make sensory discrimination and to use limited social skills. Itard had refused to accept that Victor's condition was irreversible. In the process of developing his unique teaching techniques, Itard initiated the birth of special education. By the mid-1800's, Edouard Seguin was educating children with mental retardation and had written a book on the subject. Seguin was one of Itard's students and a physician. In 1848, Seguin moved to the United States, and became a pioneer in establishing residential educational programs for children with mental retardation. He is credited with founding an organization which would become the American Association on Mental Deficiency. Additional landmarks in the expansion of services to children with disabilities include the founding of the first residential school for the deaf in Connecticut (1817), a school for the blind in Boston, Massachusetts (1832), transitional residential facilities for children with mental retardation (beginning in 1850), and a subdivision of the National Education Association concerning the needs of the physically or mentally handicapped, which would become the Department of Special Education in 1897 (Cook, 1987). In addition to innovative educational program, the 1800's also generated development of residential facilities designed to protect and shelter children and adults with a variety of mental disabilities, including mental retardation and mental illness. By the late 1890's the feelings of pity and charity that had led society to develop shelters to "protect" individuals with mental disabilities had shifted. The 1900's began with segregation. People were beginning to view people with mental retardation as a menace. Why did this shift occur?

Middendorf explains that, while most of the residential facilities were designed to be transitional educational or "habilitative" programs, over time an increasing proportion of the residents did not return home. As the population of people with severe disabilities increased, the facilities became increasingly limited to congregate (e.g. large group) custodial care. Most of the residential facilities were built in rural areas. In theory, this was because rural locations offered shelter and protection from the stresses and lack of understanding that the residents might experience in their home communities. For all practical purposes however, the major advantage appeared to be economic -- rural land and resident labor on working farms were less expensive.

As the practice of remote institutionalization continued, people with disabilities were increasingly segregated from the mainstream of community life. As a consequence, people with disabilities did not have adequate opportunities to learn community living skills, while community members lacked opportunities to develop meaningful relationships with people having disabilities. The outcome of segregation increased social apathy, distrust, fear, and social stigma regarding people with disabilities. Around 1900, the new science of genetics was beginning to influence professional attitudes in unfortunate ways. Middendorf explains that several early studies resulted in two conclusions: 1) most mental retardation was caused by heredity, and 2) mental retardation caused most social evils. While these conclusions were soon proven to be scientifically invalid, the damage to service standards for people with mental retardation had already occurred. Laws and regulations were passed which prohibited marriage, mandated surgical sterilization, expanded segregation of people with mental retardation in large congregate care facilities, and segregated people by sexes within institutions.

By the middle of the 20th century, society was trying to re-stabilize following two world wars. As soldiers returned home physically, and often mentally, disabled as a result of combat, renewed compassion for people with disabilities emerged. Beginning in the 1950's parents and professional advocates started to take action to reverse the abusive and isolationist trends of the early century. Community-based services, including day care centers and small sheltered workshops, made their debut (Cook,1987). The civil rights movement of the 1960's was a major catalyst, helping to initiate a series of class action suits which challenged the constitutional legitimacy of institutionalization. By the 1970's, federal legislation was enacted which supported the rights of people with disabilities to freedom from discrimination, free appropriate education in the least restrictive environment, due process guarantees, and community-based, habilitative services.

Once on the books and within social tradition, laws and service practices are slow to be amended. While many of the atrocities of early institutions -- such as group toileting, no heat in winter, and surgery without anesthesia -- have been eliminated, others have not. Those we continue to work actively to eliminate include: the social segregation of people with disabilities, continuation of large congregate care facilities, breaks in family ties resulting from the remote locations of residential facilities, and "institutionalization" as an accepted single solution.

Early Childhood Education:

A review of historic trends in early childhood education (Cook, 1987) suggests that early childhood advocates have been in existence for a long time. As early as the 1600's John Locke was promoting the concept that the mind of an infant was a "blank slate," challenging the popular myth that children were born full of evil. Somewhat later, Jean Jacques Rousseau argued that a child's education should begin at birth, and be grounded in compassion rather than harsh discipline. Both men were strongly opposed to the strict, and frequently brutal, treatment of children which was customary for the day.

During the 1800's, developments occurred rapidly in the field of early childhood education. By 1800, Johann Pestalozzi had established a residential school for children who had been left abandoned, or whose parents were ill-equipped to care for them, as a consequence of the French Revolution. His writings document his belief that early education should be based on the natural development of children, and that mothers were the best teachers. By 1830 the first kindergartens were being established in Germany by Federich

Froebel. First brought to the United States by Margarethe Schurz in 1856, and adopted for English speaking children by Elizabeth Palmer Peabody in 1860, by 1873 public school kindergartens were being established. These historical events reflect the increased emphasis on the concepts of childhood as a unique period in human development, and of the beginning of the "nuclear family" taking hold in the 1800's.

During the 20th century, the pace of new knowledge concerning child development and early childhood education has been revolutionary. In the early 1900's Alfred Binet was commissioned by the head of France's public instruction to design a test to identify children in need of special instruction. One of the goals was to create a measure that would avoid the problem of prejudice and to facilitate the retention of children with special needs within the regular classroom. In Italy, Maria Montessori, a physician, spent her early years working with children with mental retardation, and later developed her famous nursery school program in the slums of Rome. Other innovators of the early 1900's include Jean Piaget, who described the development of children's thinking and identified stages of cognitive development; Arnold Gisell who among other contributions, was a pioneer in developing norm-referenced developmental assessment measures and a spokesperson for maturation as a central concept in child development; John Watson whose behavioral theories led to an emphasis on the importance of environmental influences to child development; and Eric Erikson, who defined a theory of children's social development.

Followed by the work of hundreds of other early childhood and human development specialists throughout the century, we now have a remarkable base of knowledge about how children learn and develop. From the vast amount of research conducted during the 1960's and 1970's in conjunction with the Federal Head Start Program, Handicapped Children's Early Education Program, and Maternal and Child Health Early Intervention Programs, we now can make some concerted concrete predictions about the effects and benefits of early eduction programs.

C. Current Trends in Early Childhood Education - The current trend in early childhood education promotes integration of knowledge and practice previously separated into the two academic fields of "early childhood education" and "early childhood special education" . While early childhood education has generally adopted a "child centered" developmental approach, special education has generally adopted a more didactic, teacher directed, intervention approach (Cook et al, 1982; Odom and McEvoy, 1990). The theoretical and philosophical orientations of these two fields has.resulted in separate service systems -- one for children with identified special needs and the other for children without identified special needs.

The current goal in early childhood education is to blend early childhood special and regular education to facilitate the enrollment of children in noncategorical child care programs, and thus, to promote the ability and flexibility of programs to adapt curriculum according to individual developmental differences and needs. (Odom and McEvoy, 1990).

The term "integration" reflects a multifaceted functional approach to serving children with identified disabilities in regular early childhood education programs. As part of a preschool integration demonstration project, the project staff of the Family Child Learning Center, in Akron Ohio, have identified three components of early integrated child care:

- Physical Integration refers to the notion that children with disabilities will have access to the child care environment, and to the activities occurring within the classroom. This step requires that all areas of the child care environment be accessible to children, and that children with disabilities have physical proximity to other children in the program.
- Social Integration refers to children with disabilities interacting with their nondisabled peers. Research suggests that teachers often need to pay special attention to arranging the child care environment and planning activities which facilitate interaction, in order for meaningful peer relationships to occur.
- Instructional Integration refers to children with disabilities participating in regular child care program activities, with their nondisabled peers. Sometimes this will involve adapting materials or equipment to facilitate participation, or involving children through partial participation in the activities.

(Preschool Integration Network, 1990).

Appendix B highlights cultural changes in family structure, services for people with disabilities, and early childhood education from pre-1800 to 1990.

III. The Developmental Disabilities Act and Related Early Childhood Legislation

A. The Developmental Disabilities Act- The important concept to remember concerning PL 95-602, The Developmental Disabilities Assistance Bill of

Rights Act (DD Act), is that it introduced a *functional definition of developmental disability.* The primary emphasis of the functional definition is that determination of service eligibility is related to a person's ability to function in major areas of related life activities, rather than diagnostic categories. Functional skill areas included within the DD Act are:

- Self Care
- Expressing Self and Understanding Others
- Mobility
- Self-Direction
- Capacity For Independent Living,
- Economic Self-Sufficiency

According to the DD Act definition, services are to be provided to assist a person to develop *functional life skills according to the specific needs of each person.* The DD Act further designates that in order to be effective, services need to be *individually planned and coordinated within and between a variety of service providers.*

While the DD Act is considered to be landmark legislation, the rights guaranteed to people with disabilities by the act were limited by the Act's failure to include due process guarantees (e.g. legal protections). In 1981, after a decade of class action suits generated from the DD Act, the Supreme Court ruled that the rights described in the DD Act were not necessarily binding. This meant that rights and services for people with disabilities, outlined within the act, were not mandatory for states to provide. In that the current service trend is clearly guided by functional rather than categorical criterion, however, the DD Act continues to be recognized as a significant turning point effecting the provision of more appropriate services.

After fifteen years of continued advocacy and debate concerning the rights of people with disabilities, in 1990, Congress approved, and the President signed, PL 101-336, The Americans With Disabilities Act (ADA). The intent of ADA is "to establish a clear and comprehensive prohibition of discrimination on the basis of disability." The ADA provisions include protection from discrimination in employment, transportation, public accommodations, activities of the state and local government, and communications for people with disabilities. Thus, the act provides far-reaching protections for people with disabilities, comparable to rights of other groups on the basis of race, sex, national origin, age, and religion.

B. Overview of Related Early Childhood Legislation - In 1975, a year prior to enactment of PL 95-602, the DD Act, congress had already directed attention to the educational needs of "handicapped students." Until recently, PL 94-142, The Education For All Handicapped Children Act, has been the most important federal legislation concerning the lives of children with disabilities. For the first time, PL 94-142 guaranteed school aged children with handicaps a *free appropriate public education*, regardless of the severity of disability. The Act also required that education be provided in a *least restrictive environment*, and include legal recourse to parents through *due process guarantees*, if they believe that their child's right to a free appropriate education is not being met.

While diagnostic categories continued to be used as criterion for service eligibility, PL 94-142 did require that an *Individual Education Plan (IEP)* be developed for each child. By mandate, an IEP team is to include the child's parent(s), teacher, and other specialists as appropriate to a child's individual needs. The IEP is to be written following *comprehensive multidisciplinary assessment*, and is to address methods for achieving specific *behavioral objectives* as a result of clearly designated *specialized intervention strategies.* PL 94-142 also includes *state incentives* for developing early intervention programs for children birth to school age. A limitation of the Act has been its failure to provide binding guidelines defining the concept of "least restrictive environment" and in not authorizing adequate fiscal resources to fund critical supportive services needed by individual children.

In 1986, new amendments to the Education for All Handicapped Children Act, PL 99-457 extended the age *requirements for services to all three and four year olds* by the year 1991, and authorized additional incentives for development of state initiatives for children birth through age two. Other significant features of the 1986 act included introduction of a new classification term , *developmental delay,* which specifies eligibility according to five functional areas of delay listed below:

- Physical
- Cognitive
- Language and Speech
- Psycho-Social and
- Self-help

For services to children birth through age two, the Act specified development of *Individualized Family Service Plans (IFSP's)* instead of an IEP. This family-centered approach recognizes the central role of parents in the lives of very young children and, thus, the need to provide supports for the entire family unit rather than limiting the target of intervention to the child. Provisions for a broad range of early intervention strategies were authorized, which significantly expand the limited provisions of PL 94-142. The Act also provided for a state-level Interagency Council for Early Intervention.

Amendments to the Act in 1990 included officially changing the name of the Act to Individuals With Disabilities Education Act (IDEA) and changing the term "handicap" to "disability" throughout. *Appendix C*, includes a brief overview of PL 99-457.

C. Terminology Related To Early Childhood Services - One of the frequent frustrations expressed by various members of children's IEP or IFSP teams, is not having a clear understanding of other team members "jargon". Physicians talk the language of medical terms, audiologists use terms related to hearing functions, teachers use terms related to the field of education, and so on. Sometimes team members may feel that others are "talking over our heads", or unwilling to "include us" in their conversations. What really happens is that each of us becomes so familiar with the terms of our own area of specialty, that we often forget that other team members do not share our common experience or language.

Any member of a multidisciplinary team needs to become somewhat familiar with a variety of terms used by other team members. An occupational therapist, for instance, needs to understand the specialized terms and concepts used by child care providers, just as much as child care providers need to become familiar with the terms and concepts of the occupational therapist or other specialists. As child care providers begin to work with other team members in the process of integrating children with disabilities into regular child care programs, an important role is to help other team members understand the terms and concepts that are important to the field of early childhood education.

A good resource for assisting all team members to develop a common terminology is: Resource Guide to Special Education, Terms, Laws, Assessment Procedures, and Organizations (2nd Ed.), written by William E. Davis, and published by Allyn and Bacon, Inc. Boston, copyright, 1986. *Appendix D* includes a glossary of specialized terms, helpful for early child care providers who may be participating as a team member.

D. DD: Categories and Characteristics - As you have now learned, there are generally two ways of categorizing disability--medical/diagnostic, and functional. *Medical/diagnostic categories* are still used to establish eligibility for educational, as well as other services and programs. *Functional categories* are used to develop individual education, habilitation, or intervention plans to facilitate a person's development of skills that will functionally assist them in daily living. As reflected in PL 99-457, there is a growing trend in the use of functional criterion to establish service eligibility as well.

For people interested in learning more about specific diagnostic categories and characteristics of childhood disability, the book, Medical Aspects of Developmental Disabilities in Children Birth to Three, James Blackman (Editor), is recommended. Another helpful book, specifically designed for early child care providers, is Children With Special Needs In Early Childhood Settings: Identification, Intervention, Mainstreaming, by Paasche, Gorrill, and Strom, Addison-Wesley Publishing Company.

Appendix E includes an information summary and helpful suggestions for working with children with disabilities in regular early childhood settings. *Appendix F* includes a listing of service agencies working with young children with special needs and their families.

OVERVIEW AND SUMMARY

Cultural values, social practices, and individual attitudes all coexist to influence the quality of life of all people. Once established within the social fabric of myths, attitudes and traditions, social practice and social policy take time to change. Within the past twenty years, important changes have occurred in public attitudes, values, perceptions, legislation, case law and service systems for people with disabilities that deserve the title of "revolution." This does not mean, however, that the effort to provide people with disabilities appropriate community based services and options is complete. There remains a great discrepancy between states and communities related to the availability and accessibility of community options.

In some communities, early childhood services including: early and periodic screening, comprehensive diagnosis and assessment, habilitative physical, occupational or other supportive interventions, and integrated educational opportunity are available at public cost for many children. In other communities, although guaranteed by federal or state laws, they remain non-existent at any cost. As we enter the 21st century, myths about people with disabilities have been discredited and our attitudes are positive--but there is still a great deal of work to be done to assure equal availability and access to needed services for all eligible children and families!

UNIT II: DESIGNING AN INCLUSIVE CHILD CARE ENVIRONMENT

I. Setting the Stage For Inclusive Child Care

A. How Basic Concepts of Early Childhood Education Apply to Working With Children With Disabilities - All children, regardless of ability have basic needs. Children's *physical needs* include: the need for shelter and protection from harm, nutritious food appropriate to the child's age, adequate clothing, good health care, and a balance of rest and activity. Children's *psychological needs* include: consistency and affection (people who can be depended on to be supportive and caring); security and trust (people and surroundings that are familiar, reliable and appropriately respond to the child's needs); and adults who have appropriate expectations for children at differing levels of development. All children have *a need to learn,* that is: freedom to explore and experiment within clearly defined and consistent limits; freedom to make mistakes (which are identified by adults as important steps in the learning process, rather than behaviors to be punished); access to a variety of developmentally appropriate materials, experiences, and challenges; and opportunities to make personal decisions. All children *need respect,* that is: recognition that the most important component of a child's self-esteem is achieving an "I Am-I Can" attitude; sincere attention given to a child's achievements; and helping the child to recognize their accomplishments by reflecting the child's achievement . All children *need understanding,* that is: acknowledgement of the great energy and effort it takes to learn new skills, and make personal choices; and positive adult recognition of each small step children take along the way to mastery of complex skills (Allen & Marotz, 1989).

While children's basic needs are the same, every child will be somewhat different in terms of interests, learning styles, and physical attributes. We are all born with a certain "physiology" that provides the framework for our individual development. We each look unique, and "inside" we each have unique biochemical processes going on that influence our sensory, motor, and cognitive functioning. When a child has a *developmental disability* it means that he or she has impaired functioning in one or more areas of their physiological system related to sensory input, central processing, motor output, or physical, or psychological health, which is significant enough to result in functional disability in one or more areas of cognitive, social, motor, language, or self-help skill development (Healy, 1983).

Our *environment* is our stage--the place where our lives unfold. A *nurturing* child care environment is one that adequately meets the needs of a child, and promotes necessary skill development. In group child care programs, the challenge is meeting the needs of individual children in response to their particular interests, learning styles, and physical qualities. The term *transaction* is used to describe the "give-and-take" relationship that occurs between individuals and their environments which influences *behavior* and the *development* of cognitive, social, motor, language, and self-help skills.

While there are many different curriculum approaches in early childhood programs, *the learning center philosophy* is widely accepted as providing the best model for arranging environments to meet the individual child's developmental needs within group settings. The learning center approach acknowledges that children learn through play. Children have the opportunity to select areas of personal interest, and learn important skills through self-initiated discovery. Appropriate practices include providing a variety of activity areas such as dramatic play, art, blocks, large and small motor areas. Pre-academic concepts related to science, math, social studies, and language arts are included within activity areas, rather than taught through teacher directed instruction.

A good book to help child care providers to prepare an inclusive child care program is: Souweine, J., Crimmins, S. & Mazel, C. (1990). Mainstreaming: Ideas for teaching young children. D.C.: NAEYC.

B. Ways Integrated Settings Facilitate Children's Social Development - Why is the effort to provide quality integrated child care programs important? What do integrated settings have to offer children and families that traditionally segregated centers have lacked? Following a decade of research and demonstration projects concerning integrated child care, experts have compiled some helpful answers to these questions. The rationale for early integration includes psychological, educational, philosophical, socio-cultural, and political-legal considerations. Benefits of early integration have been identified for children with disabilities, their nondisabled peers, for families of children with disabilities, for families of nondisabled children, for early childhood and special educators, and for program administrators. When efforts are made by child-care centers to effectively provide integrated child care opportunities the quality of services is enhanced for all children (Bricker, 1978; Odom & McEvoy, 1990). See *Appendix G*: Integrated Services, for a summary of ways integrated child care opportunities are believed to facilitate children's' development.

One of the most essential factors for child care providers to consider in integrated programs relates to children's social development. The pre-school years have been identified as the "target years" for establishing a solid foundation for social/emotional development. The early-childhood years are a time when social relationship skills are developed. Through adult and peer interactions children learn how to initiate conversations, negotiate differences, respond to overtures of affection and aggression, and discover what behaviors "fit" what situations.

Current research evidence suggests, however, that learning effective social skills may be difficult for some children with disabilities, and that a major objective for early child care providers needs to be promoting positive social interactions between children with disabilities and their nondisabled peers (Odom, Kohler & Strain, 1987). Integrated child care settings provide the opportunity for peer modeling, imitation, and direct teaching of social skills for children with disabilities, as well as their nondisabled peers.

A good reference book discussing the social development of young children with disabilities, which includes strategies for social intervention, is: Odom, S.L., McConnell, S.R., & McEvoy, M.A. (1992). Social competence of young children with disabilities: Issues and strategies for intervention. Baltimore: Paul H. Brookes Publishing Company.

C. Identifying Ways to Promote Positive Self-Concept of Children With Disabilities - Positive self-concept is achieved/developed through the process of experiencing successful interactions between an individual and their environment, which results in a sense of personal control. "I am-I can" attitudes develop in children when their actions result in a response from the environment that stimulates a sense of "I'm feeling O.K." When the environment responds to a child's action is aversive, or negative, the child will feel, "I,m not O.K." This cycle of positive and negative "environmental responses" is what molds behavior. Poor self-esteem develops when this process gets out of balance--when negative environmental responses undermine a child's sense of stability and control.

When a child has a developmental disability (physical, cognitive, or social/emotional) it means that the rate of achieving milestones associated with the functional area of development will be delayed or impaired. For example, if a child is unable to walk, he or she will observe that other children are able to climb stairs, run, play kick-ball, and a variety of other activities that the child feels he or she cannot do because he or she cannot walk. Other children may not include the child in their activities, because the child cannot walk/run.

Unless attention is given to promoting the child's sense of personal competency and achievement, the child will be at-risk for low self-esteem.

To promote the self-esteem of a child with a disability, it is essential that: (a) the environment provides ample opportunities for successful personal interactions, and (b) adults and peers provide positive reinforcement, based on individual rather than group standards of achievement. For example, in the example offered above related to a child with a mobility impairment, attention needs to be given to:

- *adapting the environment* by providing ramps or elevators to allow for independent mobility and adapting activities to include the skills available to the child who is unable to walk, but who can compete in wheel rather than leg races, use a hockey stick when playing kick-ball, etc.
- *promoting the child's personal achievements* by helping the child to identify, promote, and celebrate their strengths (related both to functional skills in the area of disability and in unaffected functional areas), and helping other children (and adults) to recognize the child's abilities and willingness to adapt to activities and interactions as needed.

Positive self-esteem is the foundation of achievement. When teachers, administrators, or parents observe that a child is unhappy with his or her self, *action needs to be taken to build "I am-I can" feelings!*

For curriculum ideas for helping staff and children to better understand children with disabilities and help promote positive self-esteem of children with special needs, see the book: Froschl, M., Colon, L., Rubin, E., & Sprung, B. (1984). An early childhood curriculum about disability: Including all of us. D.C.: U.S. Department of Education, Women's Educational Equity Program.

II. How To Maintain A Friendly Atmosphere

A. How to Modify the Physical Environment to Encourage Positive Interactions - Early childhood educators should *always* consider ways that the physical environment can be modified to encourage appropriate child/environment interactions, before deciding to intervene directly with children. The physical environment includes room arrangement, available materials/activities, and other people. The structure provided within an environment also influences children's level and quality of involvement.

Specifically, child care providers need to consider the relationship of each of these factors to the individual child's behavioral development prior to making the determination that a behavior is inappropriate. Children's, apparently "bad", behavior may be quite appropriate given a "mismatch" between child and environment. As discussed previously, most misbehavior signals that "something is not right in the child's world." For example, if analysis of a child's behavior reveals that a two year old's temper tantrums occur when the "big kids" take her toys or "barge in" on independent play, the tantrums could be considered an appropriate behavior for a two year old under the circumstances.

Following are a list of ideas early childhood educators should consider for creating an environment which will encourage appropriate child/environment interactions:

- Considerations concerning room arrangement involve the organization and spacing of activity areas. As a primary rule, the room needs to have functional barriers to discourage running. In addition, the right balance of visual and auditory levels need to be determined in relation to: a) children's small group activities and b) individual children's tolerance for visual and auditory stimulation. . Noise levels need to be considered when arranging activity areas in order to reduce disruption from adjacent activity areas. For example, areas that encourage dramatic play are generally noisy, and would cause disruption of quiet activities occurring in the language area, if these areas were arranged next to each other. In setting up the room visual cues, or pictures, need to be included to help children return materials to their right places, and help maintain room organization (i.e., use paper cut-outs in block and kitchen areas to designate where blocks/utensils belong). In considering individual differences, it is important to recognize that some children become over stimulated when "too much is going on" in their visual or auditory fields When this occurs children may feel confused or anxious. Additional room modifications, such as additional room dividers or adding carpet, can reduce excess visual or auditory "noise" in the room, and facilitate children being able to attend to their activities.

- Considerations related to available materials/activities involve availability and variety of materials appropriate to children's developmental level. Children at different developmental levels have varying: (a) abilities to make choices, (b) attention spans, (c) ranges of skill development, and (d) interests. Materials and activities need to meet children's needs in each of these areas. When a child "acts out" or withdraws when presented with certain materials or activities, there may be an inappropriate match between material/activity levels and the child's developmental level. This is why it is very important for early childhood settings to maintain a resource closet with a variety of materials to be introduced according to children's developmental needs.

- Considerations related to other people involve group dynamics and availability of adult and peer models. Children are more likely to have desired behavior when: (a) group size is kept small (3-5 children); and (b) children are grouped together who are socially compatible and/or at similar levels of development. Adults and peers who model desired behavior/skills are extremely important. Adults need to be aware that their example is a primary teaching aid. New concepts and skills (both appropriate and inappropriate) are frequently learned by children simply by observing and modeling adult behaviors. Using "peer tutors" is also an effective way for children to learn new and adaptive behaviors through imitation.

- Considerations related to structure involves daily routines and limits/rules. Structure provided by daily routines and clear and reasonable limits/rules, provide a safe foundation for children. From this foundation, children can feel confident and free to explore their environment. Daily routines help contribute to a child's sense of personal control and trust -- children learn to predict, with reasonable accuracy, what will happen next in their day, and can then prepare themselves for expected/anticipated transitions. Reasonable limits and rules provide consistency and security -- when children understand what is expected they can be more confident in making "acceptable" choices (e.g. socially condoned and safe choices).

For additional information on modifying the child care environment to meet the individual needs of children, see *Appendix H*, "Environment Check List".

B. Positive Methods of Behavior Analysis and Problem Solving - This section will outline a functional approach to analyzing and solving behavior problems in early childhood classrooms. The approach involves three main components: (a) identify the target behaviors, including events surrounding the behavior; (b) form one or more hypotheses (informed guesses) about function/behavior relationships; and (c) based on observations, alter either the antecedent or the consequential events supporting the behavior in order to test the hypothesis.

Step 1: Identifying Target Behaviors

Identifying target behaviors, in a general way, is easy. At any given time, a child care provider will be able to identify at least five behaviors expressed by children in their programs that they would like to see "improved" or changed. In order to provide effective conditions to change behaviors, however, behaviors need to be defined somewhat more specifically. By carrying out a *functional analysis of behavior,* data is collected to provide necessary information on intervention, and evaluation. A functional analysis will often show that simple environmental changes can be made and require little or no formal data collection and direct intervention. The purpose of functional analysis is to get a global view of the target behavior, and to identify events (antecedents and consequences) surrounding the target behavior.

The format and process for conducting a functional analysis involves making a written observation record of: (a) *Antecedent* - the condition or context under which the target behavior occurs, (b) *Behavior* - the target behavior under observation (c) *Consequence* - what events or conditions occur following the target behavior.

Information is recorded on a standard record sheet such as the one that follows.

FUNCTIONAL ANALYSIS RECORD

Functional Analysis Guidelines:

1. To identify the setting in which the behavior is likely to occur, informal observation is needed before the functional analysis begins. If a behavior has only occurred once or twice, formal intervention is probably not called for.
2. Record only factual observed behaviors under sections A:B:C below - the comments section can be used to record teacher interpretations of behaviors, to make notes comparing one observation to another, etc.

3. Before beginning to generate hypotheses about function/behavior relationships, always conduct a series of observations of the behavior, under similar conditions, for a period of at least one week.

Observation Record:

Child's name:________ **Recorders name:**__________
Date:____________

Behavior being observed:

____
____

Setting:

____
____
____

Time: _______(start of observation) - _______(end of observation).

A **Antecedent** (Before)	B **Behavior** (During)	C **Consequence** (After)

Recorder Comments:

Step 2: Generating Hypotheses (informed guesses) about function/behavior relationships.

Research in the areas of pragmatics and communication, suggest that all behavior has some communicative or message value in the context in which it occurs (Donnellan, 1984). Generating hypotheses about function/behavior relationships involves answering the question: *"In the present setting/context, what message does the person (child) seem to be communicating, and how is the message being communicated?"*. Answering the question involves considering the context of the behavior, including such areas as time of day, nature of the activity, the students physiological status, behaviors of others toward the student, recent changes at home, etc.

A data collection instrument has been developed by Donnellan, et al, (1984), to assist practitioners in analyzing the communicative functions of behavior. An observation matrix is used to identify possible relationships between behavior and its communicative functions. See *Appendix H*: "Observation Matrix" for and adapted version of the Donnellan et al, model.

Step 3: Based on observations, alter either the antecedent or the consequential events supporting the behavior, in order to test the hypothesis.

After one or more hypotheses, or best guesses have been made about what the child is attempting to say by the behavior, decisions need to be made about the best approach for intervention. Decisions about appropriate interventions need to be considered in light of a *target behavior change*, which is related to the functional hypothesis. Methods of intervention may involve teaching new behaviors, altering the antecedent of behavior (e.g. the environmental context), or altering the consequences of behavior. These methods will be discussed in more detail later in the training program.

Principles of effective behavior management are outlined in the following section.

C. Principles of An Environmental Approach To Behavior Management - Children learn many behaviors, both appropriate and inappropriate, from cues in their environment. By understanding the basic principles of behavior development, child care providers can begin to identify *target behaviors,* and apply *systematic procedures* to increase or decrease the target behavior in order to teach a child functional, age-appropriate skills. Understanding these learning principles can assist child care providers to rearrange the environments of children in their programs, so that the learning of inappropriate behaviors is lessened, and the teaching of appropriate behaviors is increased.

Below are five principles of behavior management (Stevens, 1988) for child care providers to consider:

PRINCIPLE #1: **Almost all behavior is learned** - Some person, some event, or some combination of persons and events has therefore taught the behavior. Behavior we want to occur (appropriate behavior), such as following rules or requests, saying thank-you, or wearing a coat when it is cold outside,are learned. Behavior we do not want to occur (inappropriate or noncomplying behaviors) such as hitting, whining, or eating too many sweets, are learned. A few behaviors come naturally (are not learned) such as breathing, blinking, or other reflexive behaviors; these are generally not the behaviors we are concerned about when discussing environmental approaches to managing behavior.

Without really specifically thinking about it, early childhood educators work toward three goals regarding children's behavior:

1. We try to get children to do things (perform behaviors) that they can do, but often do not do.
2. We try to get children to stop doing things that they do, but should not do.
3. We attempt to teach children to do new things (behaviors) that they previously could not do.

PRINCIPLE #2: **Behavior is controlled by its consequences** - Consequences are defined as events that occur following a behavior. These events control the probability of whether the behavior will occur again, or stop occurring in the future. Consequences following behavior will have one of two affects on the behavior: (a) consequences may increase (strengthen) behavior they follow, or (b) consequences may decrease (weaken) behavior they follow.

PRINCIPLE #3: **Behavior is maintained and/or increased by consequences called reinforcement** - We know reinforcement is at work when a behavior continues to occur or begins to occur more often. If a behavior is not continuing to occur, it is not being reinforced. People do not continue to perform behaviors that are not in some way reinforced. We should not think of reinforcement as only positive events; reinforcement is any event that follows a behavior, which increases that behavior.

Some additional characteristics of reinforcement include:

a) *Reinforcement has its maximum effect when it comes immediately after the behavior and is contingent (directly associated) on the behavior.* Very young children and older children with mental retardation, generally do not associate delayed reinforcement with previously performed behaviors. For example, a child may come into the room and immediately begin constructive block-play. Five minutes later the child begins throwing blocks at the wall. A teacher comes over, pats the child on the back interrupting the throwing activity, and says "good job at getting busy this morning, tell me about what you have built here." If the child continues or increases block-throwing when in the block area, it is likely that the child has associated the block-throwing activity with the pat on the back and teacher attention, thus, the continued behavior.

b) *Reinforcers are individualized.* What may be reinforcing to one child, may not be reinforcing to another.

c) *Due to the subtleness of reinforcement, it is often difficult to determine what reinforcement is occurring to cause a behavior to be maintained or increased.* Conducting a functional analysis of the event sequence will help to identify possible reinforcers.

d) *Reinforcers can loose their reinforcing value.* If an item or event which has previously increased behavior ceases to do so, it may be due to over-use or to the immediate mood or wishes of the child. In order to maintain items or events as reinforcers, do not allow free access to reinforcers. Identify a variety of possible reinforcers for each child, so that they may be varied according to the situation and preferences of the child.

e) *Positive reinforcement means adding something desirable to the situation that increases the behavior it follows.* Examples of positive reinforcers include: social reinforcers such as verbal praise, hugs, a smile; and tangible reinforcers such as food, objects other than food, privileges or activities, or tokens accumulated and exchanged for an object or activity. Whenever possible, it is important to choose a reinforcer that represents a "natural" or "logical" consequence of the action--social reinforcers are preferred over tangible reinforcers, unless the tangible reinforcer occurs naturally as a result of the action in other settings (i.e., choice of favorite food for snack after helping to set the table).

f) *Reinforcement schedules refers to when and how often to deliver reinforcement.* Continuous reinforcement refers to delivering reinforcement following every occurrence of the target behavior. It should be used in the initial stages of increasing a behavior, and is the fastest way to increase behavior. Continuous reinforcement is not a realistic schedule to maintain, and should be faded gradually whenever possible. Intermittent reinforcement refers to reinforcing behaviors on an on and off basis. It provides a systematic way to fade continuous reinforcement, causes behavior to be stronger, and is the most naturally occurring type of reinforcement. Procedures for delivering intermittent reinforcement include delivery of reinforcement:

- after a certain number of behaviors, (e.g., every second, third, fourth behavior -- whatever the child can handle and still continue the behavior);

- or after the passage of a certain amount of time (increasing the time gradually).

Note: Most inappropriate behaviors are on an intermittent schedule of reinforcement, and therefore are very hard to eliminate. This is one reason it is important to focus on increasing positive behaviors rather than concentrating on eliminating inappropriate behaviors--additional positive behaviors give the child alternatives. If reinforcement of appropriate behaviors is more satisfying to the child than reinforcement of inappropriate behaviors, the child may choose to exhibit appropriate behaviors in place of inappropriate behaviors.

PRINCIPLE #4: Behavior can be decreased by manipulating consequences - Two general categories for decreasing behaviors by manipulating consequences include non-aversive techniques and aversive techniques. *Extinction* and *differential reinforcement* are considered non-aversive procedures.

Extinction refers to a procedure of removing reinforcement that is maintaining behavior. The procedure includes (a) defining the target behavior, (b) observing the consequences that are maintaining the behavior, and (c) removing the reinforcer. For example, the child has been verbally reprimanded for swearing, however the swearing has increased. It is expected that the reprimands are providing attention that the child wants, thus reinforcing the swearing behavior. Planned ignoring is implemented. If the swearing stops, the reinforcer has successfully been removed.

In order to feel confident using the procedure of extinction, it is important to remember that: (a) an increase in the target behavior will often occur, before a decrease; (b) aggression may occur as a rebellion of the removal of the reinforcer; (c) generalization to other situations where the reinforcement is still occurring may not occur.

Differential reinforcement refers to procedures where reinforcers are associated with behaviors incompatible with a target behavior. Two types of differential reinforcement include:

DRO: differential reinforcement of zero rates of behavior when the target behavior does not occur for a specified time period. For example, the target behavior is swearing. After two days without swearing, a child receives the privilege of renting and watching a movie.

DRI: differential reinforcement of an appropriate behavior that is incompatible with the target behavior to be decreased. For example, the target behavior to be decreased is swearing. A systematic reinforcement program, including the teaching of acceptable descriptive words to express strong feelings and systematic reinforcement of the use of these descriptors, is implemented. As use of acceptable words increases, swearing will decrease.

Because aversive procedures are not recommended for working with children in early childhood centers, details will not be provided on these procedures. They are mentioned so that early childhood educators are familiar with the concept of aversive consequences. Aversive procedures include *verbal aversives* such as scolding or reprimands; *response cost* which involves taking some thing or privilege away contingent upon an inappropriate behavior; *time-out* to remove the opportunity for reinforcement for a given time contingent upon an inappropriate behavior, *physical aversives* or presentation of an unpleasant experience, such as physical restraints or lemon juice squirted in mouth, contingent upon an inappropriate behavior.

PRINCIPLE #5: **Stimulus control describes a relationship between behavior and its antecedent stimuli rather than its consequences** - When behaviors occur due to certain environmental conditions, we say that the behavior is under stimulus control. Behaviors under stimulus control continue due to a history of reinforcement under those conditions. A reinforcing agent is the person (or in some cases object) delivering the reinforcement. When a reinforcing agent delivers reinforcement contingent upon behavior consistently, the agent may become associated with the behavior, and the agent's presence alone may be enough to bring on the behavior.

This is why it is extremely important for child-care providers to emphasize positive rather than aversive behavior management techniques. For example, a child is working on an activity and receiving no attention from teachers or peers. The child stops working at the task and begins to tickle the child next to her. A teacher calls out her name, and reprimands her for tickling causing some of her peers to look at her. If inappropriate behavior continues or increases after events such as these, the reprimands and stares have been reinforcing. If the child's behavior seems to be less appropriate in the presence of one teacher, and more appropriate in the presence of another, the chances are that the first teacher has become associated with providing attention for inappropriate rather than appropriate behavior.

An Example of Behavioral Principles in Practice

An illustration of these behavior principles applied to the ABC analysis discussed in section B, may help clarify how these work together. For example:

> A child care provider conducts a functional analysis (ABC observation) of temper tantrum behavior, and identifies that the behavior tends to occur after the child has been told to participate in some physical activity (going outdoors, playing in the large motor room, etc). The child care provider also finds that the behavior is often followed by a "time-out," at which time the child is separated from the other children, but generally permitted to play alone in a separate room. What is being "said" by this behavior?

A functional analysis of the example given above would reveal that tantrum behavior is being maintained by the positive reinforcement of being able to play alone. The analysis , also suggests that the behavior may be under the stimulus control of settings involving large-motor activities. Hypothesis about the communicative function of the behavior might include that tantrum behavior is related to communicating the message, " I don't like to run around and play outside" (protest), and/or "I like to play by myself, sometimes" (request for permission to engage in an activity). Possible interventions might include: (a) reinforcing enjoyment of large-motor play whenever it occurs

(DRI); (b) ignoring tantrum behavior, but having the child be in setting with other children (extinction); or (c) teaching the child to ask for quiet-play during selected activity periods. Based on the rule of thumb, that it is always best to focus on the positive, a good place to begin intervention would be systematic implementation of item (c), teaching the child to request time to play alone during certain activity periods and reinforcing this behavior when it occurs . Thus, the targeted behavior change becomes: "The child will demonstrate increased ability to request time to play alone during (specified) activity times." This goal statement, clearly places positive emphasis on the child's development of a new skill, rather than emphasizing the child's inappropriate behavior.

D. Procedure for monitoring intervention strategies:- The basic procedure for monitoring behavior change involves daily collection and recording of data for at least three sessions before an intervention strategy is introduced (baseline data) and 5 to 10 sessions following introduction of the selected intervention. Additional sessions may be included for monitoring maintenance, following fading of direct intervention strategies. It is strongly recommended that primary attention be focused on monitoring desired behaviors (target for behavior change) rather than the initial inappropriate target behaviors. Additionally, some child care providers prefer (or are required) to monitor both the decrease in target behavior and increase in the target for behavior change.

Three direct observation recording techniques can be used for data collection, depending on the type of behavior under consideration. These include: event or frequency recording, duration recording, and time sample recording.

Event/Frequency Recording Event recording involves recording the number of times behavior occurs within a specified time period. Some devices helpful for collecting data are a golf counter, a bead bracelet, or transferring dried beans from one pocket to another. Event recording is most useful when monitoring behaviors that are brief, have a definite beginning and end, and occur at a steady rate (i.e., raising hand to ask question, washing hands, hitting, swearing, etc.). Information provided through event/frequency recording includes the number of occurrences and the rate of occurrences.

Duration and Latency Recording Duration recording involves recording the amount of time between the initiation of a response and its conclusion. Latency recording involves recording the amount of time between presentation of stimulus and the initiation of the response. A stop watch is useful for duration or latency recording. Duration or latency recording is most effective with behaviors that occur less frequently but last a relatively (or inappropriately) long or short period of time (i.e., putting toys away, getting ready to go outdoors, tantrums, etc.). Information provided by duration recording includes: (a) behavior frequency, (b) duration per occurrence, (c) total duration, (d) rate of occurrence, and (e) mean duration per occurrence. Information provided by latency recording includes the amount of time elapsed between presentation of a stimulus to initiation of student response, and the mean response latency.

Time Sample Recording Time sample recording involves dividing observation periods into short interval with the observer recording occurrences of behavior at the end of each interval. Time sample recording is most effective with behaviors that occur at a high rate and when sample data is adequate for measurement (i.e., on-task behavior, voice level, off-task behavior, etc.. Time sample recording has the benefit of allowing an observer to monitor several behaviors at one time, and easily recording several behaviors while doing other jobs. Some type of prompt will be needed as a reminder to record, such as a tape recording, kitchen timer, wrist-watch, or alarm. Information provided by time sample recording includes frequency of behavior and rate of occurrence.

For ideas on charting and tallying direct observation data, see *Appendix H*, "Sample Recording Forms and Tally."

III How To Ensure Health And Safety For All Children

A. *Health and Medical Issues Related to Specific Disabilities* - The health service needs of children with disabilities can be similar to their non-disabled peers, or can require the most extreme forms of medical intervention. Health care for children with disabilities who are not in need of extraordinary health care services is generally delivered through regular community health care service systems. Community-based health care services are the preferred form of health service delivery because they are both more "normalizing" and "cost-effective". Sometimes health needs contribute to or complicate developmental disorders. For example, the primary disability of children with Down syndrome is impairment within the central processing system, with mental retardation contributing to functional disability in cognitive development. However, children with Down syndrome also frequently experience heart and upper respiratory problems requiring medical intervention (Healy, 1983).

In order to have adequate information about the health care needs of children with specific disabilities, it is critical that the child care center have a mechanism for obtaining health status information from health professionals. In order to obtain this information, centers will need to involve parents in arranging for their child's health care provider to forward information requested by the center. Standard questions to have answered by health professionals include:

- Does the child have any extraordinary health care needs?
- If so, how will these health care needs affect the child's participation in center activities?
- Are there specialized medical procedures that child care staff should know about in order to provide safe and adequate child care?
- Are there emergency procedures that child care staff should know about, in order to be able to respond appropriately?

If a child's physician indicates that there are extraordinary health care needs requiring specialized procedures, the next step will be for staff involved with the child to obtain direct training from a recommended health care provider. Alternatively, staff should work with the child's parents and health care provider to arrange for a community health nurse to carry out needed medical procedures within the early childhood setting.

See Appendix I: "Medical Examination Report" and "Medication Authorization Forms", for examples of forms to use in recording medical information.

B. Accessing Instruction on the Proper use of Medications or Assistive Devices From Qualified Professionals - One of the factors "distinguishing" children with disabilities is their unique set of developmental needs that may involve the expertise of a variety of professionals. Interdisciplinary or transdisciplinary service delivery is the hallmark of appropriate services to children with disabilities. No one specialist can, or is expected to, meet the variety of possible service needs. To be effective, however, specialists do need to work in cooperation to provide a coordinated service plan.

The role of the child care provider is to be aware of the community services available to children and families, make referrals as needed, and/or consult with specialists in these agencies to obtain additional skills in meeting identified service needs. If a child has an identified developmental disability, the child's parents will be involved as a member of the early intervention team, and will be able to help child care providers arrange consultations with specialists to help integrate the service plan with center activities. If the child care center is concerned that the child may be at risk for developmental disability, parents will need to be contacted to discuss these concerns, and be assisted in obtaining appropriate screening and evaluation services for their child.

C. Developing and Implementing a Checklist for Center Safety - Training in the provision of health and safety for children, related to developmental disabilities would not be complete without information on prevention of disabilities. Public health data for 1986, for children ages 1-4, indicate that 35-40 children/100,000 died as a result of injuries, while 68 of every 100 hospitalizations for children in this age group were due to injuries. The five major causes of childhood injury are motor vehicle accidents, fires/burns, drowning, choking/poisoning, and falls.

Injuries, unlike many other causes of death or need for hospitalization, can be prevented. The three primary conditions necessary for preventing childhood injury in child care settings are:

1. know the capabilities of children within your care;
2. provide and maintain an environment that meets recognized standards of safety for young children; and
3. develop safety training programs for staff as well as children, in early childhood programs.

Every early childhood classroom needs to have a procedure for conducting routine safety checks. Both indoor and outdoor activity areas need to be checked for safety hazards at least weekly. All child care providers must be given both the authority and responsibility for taking immediate action to remedy hazardous conditions at any time that the hazards are observed.

As special safety considerations are identified pertaining to the needs of individual children, routine safety procedures need to be modified accordingly. For example, it is known that smooth, highly waxed floors may present an increased hazard for children with limited balance, because this type of floor covering is more slippery. A simple remedy for this situation is to increase surface traction by securing textured rubber floor runners in hallways and to put industrial pile area carpets in major activity areas.

See *Appendix I*, for a safety checklist appropriate to integrated child care settings.

UNIT III: WORKING WITH PARENTS AS PARTNERS IN INCLUSIVE CHILD CARE SETTINGS

I. Involving Parents As Partners

A. Why Parent Involvement is Necessary For Setting Functional Goals and Objectives - Parent Involvement is not a new concept for early child care providers. Virtually all early childhood programs complement the initial center visit and orientation, and the daily drop-off/pick-up routine with some type of parent center activities. Examples of ways in which early childhood programs involve parents include such activities as parent education programs, scheduled parent meetings, parent newsletters, parent bulletin boards, parents invited parties, and field trips. In addition, Head-Start Programs and parent-cooperative nursery schools have a long history of involving parents as active board members, and many of these programs encourage parent participation within the classroom or other aspects of the child care program as well.

The reason that parent involvement becomes necessary when working with children with disabilities is the need for programs to identify individualized functional goals and objectives, and to implement program strategies, designed to address children's special needs. Most child care programs are designed to be child-centered, with classrooms arranged to encourage independent choice and self-paced development. These programs can be excellent child care environments for children with disabilities. We know, however, that children with disabilities may need added assistance in order to fully participate in center activities. For example, children with multiple or complex physical disabilities may need special services related to positioning, personal hygiene, or adapted materials and equipment to facilitate communication or mobility. Likewise, a child who is mentally retarded may need additional guidance and direction in learning how to make choices, or how to use center materials and equipment.

Parents are the people who are most familiar with meeting their child's specialized needs on a daily basis. Parents are, therefore, the primary resource for assisting child care providers in taking an inventory of (a) what skills the child needs to promote independence in current and future environments, and (b) what steps or methods can be used to assist the child to develop these skills.

The rationale and principles for working with parents of children with disabilities are the same as those for working with the parents of any child. We know that: (a) the people most familiar with any child's accomplishments and needs are family members; (b) when school and home retain similar goals for children, the child will be more likely to reach his or her full potential; and (c) the consideration of ways to promote independence in home, school, and community settings is critical for writing meaningful instructional goals and objectives (Powell, 1989).

Examples of these principles in regular child care programs include the exchange of information between parents and teachers concerning toilet training, eating, nap-time and other daily routines; planning field trips or other curriculum activities that reflect common neighborhood and family interests; or discussion of a "new" or "unusual" behavior that is causing difficulty for the child at home or in the center's program.

These three principles apply to working with parents of children with disabilities in much the same way. The following examples highlight some of the reasons it is important to work with parents as partners in planning meaningful programs for children with special needs in integrated child care settings.

1. *The people most familiar with a child's accomplishments and needs are family members*. Parents of a child with an identified disability will, in most cases, be experienced in using a variety of methods to facilitate their child's development. Many parents may have been involved with a series of "professional experts" since their child's disability was recognized, who have assisted family members to learn special techniques, or interventions to carry out at home. Parents, brothers or sisters, and extended family members may be actively involved in using these special techniques to facilitate the child's development at home and in the community. With a child who child care staff suspect may be experiencing a developmental delay, parents will be able to assist the staff or the early intervention team assessment process, by providing information about the child's abilities in home and community settings.

2. *When school and home retain similar goals for children, the child will be more likely to reach his/her full potential* . Parents need to be consulted to ensure that goals and objectives important to the child's optimal development are included both in the center's program planning, and in the home. It is important that the specialized goals and

objectives being implemented by the family and specialists, other than child care staff, are also carried over in the child 's center program. We know that the **generalization** of learned skills depends on the continuity of application and reinforcement in a variety of settings.

3. *Considering ways to promote independence in home, school, and community settings is primary in the writing of meaningful goals and objectives* . A common reference point for specialists working with children with disabilities is enhancing independent participation in community activities (e.g., activities of daily living). In order to plan functional objectives, child care staff will need to know what the parents' priorities are related to their child's participation in home and community settings, and what goals and objectives the parents are working on at home.

B. How and Why Parent Involvement Can Vary - While the majority of parents do not have any formal training in ways to meet the ongoing challenges and demands of raising children, typically parents do have a history of social experience and social standards to choose from in making parenting decisions. Parents of children with disabilities, however, must not only address the regular challenges of parenthood, but also the unexpected and stressful issues related to the specific nature of their child's disability. Each transition will bring new questions and concerns, for which there are no "ready answers."

When a family is first confronted with the suspicion or confirmation of a child's disability, family members often experience shock followed by an intense emotional reaction. Once the family regroups and gains some organization, a period of searching for answers will emerge. Eventually some resolution of the situation will occur, and family life will begin to stabilize (Foley, 1981).

Throughout this ongoing adjustment and adaptation process, family members will sometimes want more and sometimes less involvement with "outside people." Each family has its own structure, roles, values, beliefs, and coping styles. Respect for and acceptance of this diversity is the foundation of family-centered service delivery. Parent involvement with their child's service providers will depend on these various factors, in addition to the changing internal and external issues and demands experienced by individual family members over time. Each family, and the individuals within families, will ask for help in their own way, and on their own time. The challenge for any human service provider, including early child care staff, is to know how to recognize and respond to parent cues.

While parent involvement should always be welcomed and encouraged, early childhood educators need to respect parents' right to privacy and their choice about when they wish to be more or less involved in their child's program planning activities.

Following is a brief review of some of the issues parents can face in adjusting to their child's disability and in negotiating the special service system, along with several recommendations for ways child care staff can help support parents in their journey.

Issues of Infancy and Early Childhood

The newborn with a disability knows nothing of his or her disability. Not having prior knowledge of how things "should be," the baby comes into the world with a need for protection, care and love just as any newborn needs these things. It is the baby's parents who are dealing with shock, worry, and disbelief. Not all babies born with a disabling condition will require intensive medical treatment, however, if a baby does require surgery, or needs to remain in a neonatal intensive care unit for a prolonged period of time, parents may have increased or exaggerated fears about their ability to care for their baby when she/he is ready to come home. In addition to coping with the emotional crisis and the routine care of new-parenting, issues of infancy may include a need to establish relationships with early intervention specialists who can assist the family and baby with needs relating to positioning, feeding adaptations, or continuing medical issues.

This is a period of extreme emotional crisis for parents. Professional sensitivity to the parents' emotional state is critical for optimal family adjustment. Professionals involved with parents of a newborn with a disability have a responsibility to assist in the parents' adjustment by being available to listen and discuss parent concerns, as well as attend to the needs of the baby. By focussing on what the baby can do and assisting parents to recognize the baby's developing responses; by listening to parents' concerns and supporting parent strengths and abilities to meet these challenges; professionals will, thus, be enabling family members to respond to the baby as a person with unique personality and potential rather than as a crisis.

Due to the plasticity of development during infancy, the extent of functional disability cannot be accurately determined. It is during the early childhood years that the extent of a child's disability begins to be confirmed. Parents of children with multiple or severe disabilities are faced with the challenge of seeing other children reach developmental milestones of standing, walking, and talking, when their child is not able to do these things. It is at this time that parents' fear and sorrow may be renewed as decisions about their child's future begin to take on concrete significance.

Parents want "the best" for their children, regardless of ability. Issues of early childhood include the need to identify and access services providing opportunities for independent mobility, peer interaction, and age-appropriate learning. If services to meet their child's individual needs are not available in their community, parent responses of frustration or anger concerning the lack of services can be expected. Professional responsibility includes the need for assisting parents to identify and access these services.

Financial issues related to paying for specialized services remain a real cause for anxiety and concern for many families of children with disabilities. Public subsidies or direct payments often cover only a fraction of the cost of early intervention services. To make this situation more confusing for families, public policy has not clearly delineated what agency is responsible for what services. Education agencies will claim some needs are health issues, while health agencies will claim some needs are education issues. Meanwhile, the family is left without access to services, or made responsible for paying the hefty bill. Because financial stability contributes to family stability, professionals need to be particularly sensitive to family financial dilemmas. Every effort needs to be extended to help families understand their rights to services, how to access available financial assistance and, when assistance is not available, to arrange flexible payment schedules (Miezio, 1983).

The Process of Coping

In the words of Ann Turnbull, a parent of a young adult son with a developmental disability:

> *Frequently, I have characterized parenthood of a child with a disability as being a marathon rather than a sprint. The real issue for families in preventing institutionalization, achieving community integration, and meeting the special needs of their disabled youngsters is to remain intact over time, and develop the kinds of relationships that remain vital and resilient over time.* (1988).

Perhaps the greatest challenge for families, is to adequately negotiate their grieving process, so that attention can be devoted to "getting on with life." In the textbook, *Adapting Early Childhood Curriculum for Children With Special Needs"*, Cook, Tessier, and Armbruster present a model of possible stages of reaction to having a child with a disability. They caution that the stage model should be used wisely, with a clear understanding that the progression through stages, and reactions within stages will be different for different individuals. The model can also be viewed as a cycle. Acceptance does not result in complete resolution, and the family may reexperience any stage of the cycle as children move into new situations and experiences that trigger renewed emotional crisis. Others prefer to identify stages as states, recognizing the phases of the grieving process without reference to a specific sequence.

Adapted from Kubler-Ross' grieving process related to death and dying, the five stages include: (1) Shock, Disbelief, Denial; (2) Anger and Resentment; (3) Bargaining; (4) Depression and Discouragement; and (5) Acceptance. At each phase, parents may exhibit behaviors that reflect their own emotional state.

In general, early childhood educators can help by: a) being active listeners without feeling the need to defend, rescue, or solve parent problems; b) modeling patience and praising progress; c) involving parents in plans and activities for developing their child's strengths and abilities; and d) assisting parents to access community services and plan for effective transitions between these services. See *Appendix J:*"Common Responses of Parents With Special Needs Children", for a chart outlining the stages of the grieving process, and recommendations of how early childhood educators can be supportive of parents who may be experiencing grief.

C. Strategies For Involving Parents As Partners In Program Planning - As increased emphasis is placed on parent involvement in the development of individual education plans for children with disabilities, practitioners have looked for more effective ways to include parents in the planning process. *"Family centered services"* is the term commonly being used to characterize the nature of program services considered to be effective in working with families of children with disabilities. In fact, the family centered model is quickly becoming the model of choice across various human service fields.

The term recognizes the family's primary responsibility for caring for its own members, and has the service goal of *"enabling and empowering"* families to carry out their responsibilities. *Enabling families* means helping families to build on their unique strengths, resources and abilities through provision of opportunities to apply and build new skills necessary to meet the needs of their children and families. *Family empowerment* is both a process and an outcome. From the perspective of service providers, it means interacting with families in a way which both respects and enhances a family's sense of control over their family life. From the families perspective, it means achieving a sense of control, and attributing positive family results or changes to their own strengths, abilities, and actions.

An empowerment approach to service delivery requires that staff re-examine their traditional roles and practices, when necessary, to create practices that promote mutual respect and partnership. Some of the activities associated with this approach include: consulting with families about program choices and priorities; mobilizing existing resources and supports within families; "linking" families with community resources helpful in building additional supports; and, coordinating or participating in multiple agency team planning and intervention activities.

The Individualized Family Service Plan (IFSP) Training Project (IHDI, 1989), has developed a philosophy and framework for delivering family centered services in early intervention programs. The "Family Focused IFSP Training" approach is based on value assumptions derived from family empowerment theory and research. Two vital skills child care providers will need to effectively implement a family centered approach are: (a) good communication and (b) problem solving. The following sections provide an overview of the value assumptions and strategies included in the IFSP Training Project approach to involving parents as partners in program planning.

Philosophy and Framework For Family Centered Services

Value Assumptions - The consensus in the field of early childhood services appears to be a reflection of what families are saying that they want and need in early services. Core value assumptions are that early intervention services need to: (a) support the family, (b) include respect for family diversity and choice, (c) enhance community participation and family strengths and resources, and (d) be family friendly. Each of these core values includes several supporting value assumptions related to the provision of family focused services.

Support the Family

- Be family-centered rather than program centered. We know that development for children can best be accomplished through making it possible for families to support and nurture their children. Infants and toddlers are particularly dependent on their families for survival and nurturing. This dependence necessitates a family-focused approach to early childhood programs. As children with disabilities move from infancy through high school, they are frequently "passed around" from one service provider to the next. The only constant in a young child's life may be his or her family. What makes sense is to support the family to support the child. Services that ignore the needs of the family, in favor of the child, are not acceptable.

- Balance the needs of the whole family. Thirty years ago, social attitudes supported the practice of sacrificing the needs of the child to the needs of the family through the practice of institutionalization. In efforts to build community-based services for children with disabilities we need to be careful not to sacrifice the needs of the family. Child care providers need to be sensitive to the increased demands on families of children with disabilities. It is of little use to serve the child if the family supporting the child falls apart.

- Develop interagency cooperation . No single health, education, or social service agency can, or is expected to, meet the total needs of a given child or family. Interagency collaboration and coordination is the hallmark of best practice in early services, because it allows the family to be at the center of the "service universe," and is both the most effective and most efficient way to plan and implement needed services.

Respect Diversity and Choice

- Individualize services to accommodate diversity, and a range of family needs and preferences. If programs are to be truly family-centered, programs must be able to adapt to the needs of the family and child, rather than expecting the family or child to "fit the program." Each family has its own structure, roles, values, beliefs and coping styles. An inclusive definition of family encompasses two or more individuals who define themselves as family, and assumes long-term commitment to the roles and responsibilities considered essential to family cohesion. Respect for and acceptance of family diversity is a cornerstone of family-focused services, and holds true for all families, regardless of ethnicity, cultural background, or socioeconomic status.

- Provide opportunity for families to be in control to the degree they choose. The only appropriate way to individualize family services is to include families in the decision-making process, taking into account family goals and priorities. Family direction is important in all aspects of service delivery. The family is the center of services, and is composed of the people who are ultimately responsible for determining and directing the involvement of an early intervention program in their family life.

Enhance Community Participation and Family Strengths

- Enhance the family's and child's capacity to be part of the community. Early services should be oriented toward using, adapting, or developing services and programs that integrate children with disabilities and their families with those who do not have disabilities. Early childhood programs need to include activities that will help the child learn adaptive skills that facilitate community integration in child care and future educational programs, as well as other community activities.

- Encourage families to use natural supports and resources. The most important resource for meeting family needs is a family's own strengths and resources. A responsibility of early service providers is assisting families to build on these resources rather than relying extensively on outside supports. When outside services are needed by the family, families should have access to the services provided in a normative fashion and environment, which promote integration of the child and family within the community.

Family Friendly Services

- Design early services to be flexible, accessible, and responsive to family needs. This implies an ability to adapt the program, not only for different families, but for the same family at different times. Flexibility allows for the responsiveness to the complex changes families of children with disabilities may experience. Flexibility also implies that the process of integrating children with disabilities in regular child care programs should be responsive to families needs and prior experiences, rather than following a lock-step standardized procedure.

- Take the time to build rapport with families, and be nonjudgmental and sensitive to the family's emotional needs. The program must be respectful of family privacy, and avoid intrusiveness in asking questions or delivering services. Service providers should be careful not to overburden families with unrealistic expectations for participation, and remain sensitive to the family's emotional context. Service providers should avoid using terms that imply that the family or child will be labeled or judged (e.g.developmental assessment), and terms that may be offensive or dehumanizing (e.g. case management).

(Adapted from: "Family Focused Individualized Family service Plan (IFSP) Training Project - IFSP Training Guide", IHDI Human Development Institute, 1989.)

Communication Skills - Good communication skills begin with creating a trusting and respectful relationship. Families will not be ready or willing to discuss sensitive issues relating to their child's development, unless they feel comfortable and at ease with their child's care provider.

Routine Communication Strategies

Common ways child care providers communicate openness and trust with parents is to have one staff member be a "greeter" at drop-off/pick-up times. Providing a positive, friendly, encouraging, welcoming and supportive atmosphere at these points, even though brief, helps ease the transition between hectic adult schedules and "kid time." Another communication technique is taking the time to share progress notes with parents on a regular basis. Progress notes help focus attention on a child's strengths and abilities, rather than focusing on inabilities. Some examples include: weekly "happy grams," letters from child to parent; picture snap-shot stories, etc. Given that teacher/child ratios range from 1:4 to 1:10 depending on the age of the child, child care providers can reserve time to share progress notes with at least one parent a day. This means that parents of infants could receive at least one progress note a week, while preschoolers' parents could receive progress notes at least once every two weeks.

Effective Communication Skills

In addition to reflecting caring and sharing attitudes, knowing how to use sensitive communication skills is essential for easing the transition between the upbeat nature of daily progress, and discussing sensitive issues with parents. *The Family Focused IFSP Training Project (*IHDI) identifies five key communication skills. These include: listening, reflecting feelings, reflecting content, and questioning, as illustrated in the following matrix.

Family Centered Communication Matrix

Communication Skills	Skills to Practice	Behaviors to Avoid
Listening Skills: The ability to focus and follow what a family has to say. Rationale: • conveys acceptance and understanding • builds trust and good working relationships • helps a family to relax and concentrate on the purpose of the meeting	Effective listening skills need to be used throughout conversations with families, and are especially critical at the beginning of family meetings. Nonverbal listening skills • express interest through your facial expressions • make varied and natural eye contact • maintain relaxed and attentive body posture • use non-critical and accepting body language (e.g..gestures that mirror gestures of family) Verbal Listening Skills • make responses that are relevant and follow from family members comments • use language and speech patterns that reflect family use • listen for family to stay on topic • be comfortable with family silences	Some behaviors act to close relationships with family members, and should be avoided. Nonverbal behaviors • do not take notes • do not stare • do not turn your body away from family • do not assume a rigid posture or tense facial expression Verbal Behaviors • do not interrupt • do not talk too much • do not give advice too quickly • do not moralize, criticize, or pass judgement on the family • do not talk about yourself
Reflecting Feelings: The ability to identify family members' feelings and reflect those back accurately and sensitively. Rationale • families become more aware of how they feel and can evaluate the appropriateness of their feelings • helps the family to identify and solve problems • lets the family know that you can sense the world the way they perceive it	Reflecting feelings in response to all types of emotions(eg., negative, positive, mixed) is appropriate at most points during an interview. This approach is particularly helpful when a family is having a hard time continuing the interview. Reflecting Feelings Skills • be aware of what a family says as well as how it is said • reflect feelings in a clear concise manner • respond to all aspects of a family's feelings (e.g. what is said by each family member, and how each member says it) • helps build a good relationship	When reflecting feelings, we need to take care to remain objective. Because we may be feeling strong feelings ourselves, we need to take extra care to avoid the following behaviors. Inappropriate Reflecting Behaviors: • do not overstate or over-interpret a family's feelings • do not reflect strong responses which tend to alienate the family • do not give advice as you reflect feelings • do not become long-winded or analytical.

Reflecting Content: The ability to restate the content of a family member's message through paraphrasing and summarizing. Rationale • lets the family know that you are accurately understanding their message • highlights important aspects of the discussion • secures consensus and agreement between the family • helps make connections between relevant aspects of the discussion • summarizes what has been discussed.	*Paraphrasing* involves restating the family member's message in other words. Paraphrasing can be used to confirm and clarify what a family is saying. *Summarizing* involves presenting what the family members have said in a brief concise form. Summarizing can be used to give organization and direction to the interview, and to facilitate goal setting. Reflecting Content Skills: • reflect content in a concise and clear manner • reflect the family's message accurately • give equal emphasis to various topics discussed in summaries • summarize in an organized and brief way • vary reflection of content with other types of responses.	It is important not to overuse the communication technique of reflecting content . Overuse of this technique has a parrot-like effect which may inhibit the family's communication. • do not be judgmental in reflecting content • do not make assumptions about what the family means • do not parrot what a family member has said
Effective Questioning: The ability to use open-ended questions to facilitate the discussion of topics of interest. Rationale: • open-ended questions elicit a more elaborate response than close-ended questions • helps the interviewer develop an understanding of the family (i.e assessment) • helps the family to consider the implications of current or potential actions or situations (i.e., goal-setting)	The three types of open-ended questions used in family interviews include: •**"What"** questions, which often are fact-oriented ("What types of things have you tried with Johnny to help him improve his finger feeding?') •**"How"** questions, which are often people or feeling-oriented (ex. "How are you feeling about the things you have tried?" "How has the therapist been helpful as far as Johnny's feeding?" •**"Could"** questions, which provide flexibility of response ("Could you tell me more about how Johnny's brother interacts with him during mealtime?")	Questioning practices which elicit defensive responses or do not provide adequate information should be avoided. • do not use too many "why" questions • do not use closed-ended (e.g. yes or no) questions

The Family-Focused Interview

Whatever the purpose of an interview with parents, whether it is the first orientation meeting, a regularly scheduled parent meeting, or a special meeting called to address some issue, two objectives must be accomplished. In order for the interview to be effective, child care providers must: (a) create a trusting and respectful relationship, and (b) gather information which addresses the objective of the interview.

Five phases are involved in the family-focused interviews process. Keeping written notes during the interview may be helpful, however, the emphasis needs to be on open discussion rather than a formal data collection process. Always practice effective communication skills, and always allow sufficient time following the interview to write down information, outcomes, activities, and time frames discussed during the interview. The Five Phases of the Family Interview Process include:

1) *Preparation*
   - Consolidate and summarize family/child information related to objective
   - Note information discrepancies or gaps that the interview can clarify
   - Clearly recognize and clarify both the family and interviewers goals
2) *Introduction*
   - Confirm the purpose, format, and structure of the interview, including the following criteria:
     1. The purpose of the interview
     2. The time allotted
     3. The format to be followed
     4. Confidentiality and procedural safeguards
     5. Structure of the physical environment to facilitate process
3) *Inventory*
   - Validate and elaborate on the information already gathered
   - Convey to the family that you are there to listen rather than advise
   - Let the family do most of the talking
   - Use effective communication skills to guide the interview process
4) *Outcome Setting*
   - Confirm that all topics and issues of relevance have been covered
   - Briefly summarize what has been discussed
   - Ask the family if they agree with the summary
   - Assist family to identify and develop meaningful outcomes
5) *Closure*
   - Express appreciation for the families time and effort
   - Make plans for future meetings
   - Restate strategies and activities to be carried out before next meeting
   - Give the family an opportunity to reflect on feelings about interview

Problem Solving

In addition to effective communication, good problem-solving skills are needed for helping families address their needs. The P.L. 99-457 initiative to include interdisciplinary family focused planning in service delivery to infants and toddlers with disabilities, introduced a need to design a method for involving parents more actively in the plan process. The family needs solving approach, developed by the IHDI-UAP Family Focused Training Project, introduces a six step strategy for helping families to identify problems or needs and to identify ways of effectively and efficiently responding to them. While primarily designed as a method for IFSP development, the approach is easily modified to meet the general planning requirements of child care providers. The method is equally useful for addressing family concerns and priorities in planning programs for all children, regardless of ability.

Six Components of The Needs Solving Approach:

1) *Defining the Need(s) and Identifying Outcomes*

Informal interviews or checklists may be used to initially identify family needs and priorities. This information can be used to begin the initial process of planning services. Family needs may not always be clearly defined at first, or different family members may define different needs and priorities. It is also important to keep in mind that child care providers are not, and cannot, be expected to address all needs identified by the family. As needs are identified, it is important to help clarify which needs can be adequately met through combined child care and family resources, and then to suggest alternate community agencies that may be able to help address needs which the child care program does not have adequate resources to meet.

Once agreement has been reached on which needs can be addressed through the child care and family resources, it is time to begin translation of the need into an outcome the family wants to attain.

2) *Brainstorming Alternatives*

Brainstorming gives family members and child care providers the opportunity to generate various alternatives to reach the desired outcome. During a brainstorming session, each person has an opportunity to suggest ideas about how the identified need might be addressed. It is helpful to list the ideas on a flip chart or blackboard so that all members of the group can see the list. The important point to remember during the brainstorming step, is that it is a time for generating as many ideas as possible - not a time to discuss the pro's and con's of the ideas. Evaluating and choosing alternatives comes next.

3) *Evaluating Alternatives*

This is the time to think and talk about the ideas that have been generated and to evaluate their usefulness in attaining the outcome identified by the family. Within the discussion it will be necessary to talk about the barriers, strengths and resources available to implement each of the alternatives. Barriers may be physical (e.g., no time, too expensive, lack of transportation), or they may be a negative impact on the family, child, or child care program. Resources and strengths can be identified within the family or child care program, or include other community resources. Again, listing strengths and barriers for each alternative will help everyone to focus objectively on possibilities. Choosing alternatives is the next step.

4) *Choosing Alternatives*

Once each of the alternatives has been discussed, and the strengths and barriers noted, the family needs to be given the opportunity to select one or more alternatives to implement. Child care staff should avoid making choices for the family. Sometimes families may choose alternatives that appear to have barriers that child care providers think cannot be overcome. Rather than vetoing the choice, child care staff needs to ask the family to suggest how the barriers can be overcome. Often creative discussion of how to overcome barriers can result in solutions that offer best options for the child, and work out equally well for the family and child care providers. Once alternatives have been selected, the next step is taking action.

5) *Taking Action*

This is the step where the family and child care providers will make a list of things to do in order to implement the plan, as well as to identify how all people involved will be able to tell if the plan works. The course of action is discussed and decided upon. Arrangements are made for necessary resources and activities. Time lines are determined to identify *who* will do *what* by *when*. Plans are made for ongoing progress evaluation and for a follow-up meeting to discuss progress. The plan is then carried out.

6) *Ongoing Evaluation*

Monitoring the family-needs solving approach is an ongoing process, involving the child, family, and child care staff. Open lines of communication are needed to ensure that any changes or alterations to the plan can be made as needed. Questions that family members and child care staff will want to consider include: (a) Is the action meeting the needs identified by the family; is the action moving the child/family toward the desired outcome (e.g., is the plan proving to be effective), and (b) Is the action putting undue strain on family or child-care resources (e.g., is the plan proving to be efficient) ?

See *Appendix J,* for a summary of the Family Needs Solving Approach and a standard record-keeping form

D. Plan How Parent Information Will Be Shared With Other Staff - In order for parent information to be used effectively to develop functional goals and objectives, child care programs will need to plan how to share parent information with other staff. In order to use information from parent meetings to develop functional goals and objectives, child care providers will need to involve all persons relevant to implementing the curriculum activity plan. Information on team process skills can be found in the Content Summary under the heading *Using Effective Team Process Skills to Maintain Positive Relationships Among Team Members* (pp. 54 - 57). These skills are as important to practice among child care center staff, as they are for members of an interdisciplinary team.

Another consideration related to sharing information from family interviews is *confidentiality*. One aspect of confidentiality concerns record keeping. According to federal guidelines, parents of a child must be guaranteed the right to confidentiality of personally identifiable information, including:

(a) The name of the child, the child's parent, or other family member.
(b) The address of the child.
(c) A personal identifier, such as the child's or parent's social security number; or
(d) A list of personal characteristics or other information that would make it possible to identify the child with reasonable certainty.

To assure compliance with these guidelines, child care centers need to determine who, within the center, will be authorized access to the children's files. In some centers, all personnel will be eligible to review files, because each staff member is part of the child care team. In larger centers, each classroom should retain separate files, and the information should not be shared between classroom teachers, unless authorized by center administration. Files should always be kept in folders, and put away in file cabinets so that unauthorized persons will not have open access to the records. Children's records, or information within these records *may not be shared with any outside agency or person,* unless parents have given specific *written consent*. Parents, however, must be given the opportunity to inspect and review records relating to their child.

Another aspect of confidentiality involves procedures for sharing family information with other direct child care staff. Many times parents who have developed a trusting relationship with a particular staff member will talk openly about personal concerns or problems, as they might to other "friends." This information should be treated with confidentiality, and not shared with other staff, unless specifically related to program planning activities. Only topics relevant to developing and implementing functional goals and objectives for the child should be discussed with other staff members.

UNIT IV: COORDINATION OF ASSESSMENT AND PROGRAM PLANNING

I. Working With An Early Intervention Team

A. The Early Intervention Team - When parents enroll a child into a child care program, they depend on the child care providers' knowledge and experience to provide quality child care services. They expect that children will receive not only supervision to ensure their child's safety, but also that an appropriate child care program will be provided to encourage their child's growth and development. When parents enroll a child with identified disabilities in a child care program, child care providers immediately become part of a community or regional network of people helping to provide effective strategies related to the child's growth and development. Members of this *early intervention team* may have been working with the family for several months or years, providing a variety of assessment and early intervention services.

To ensure coordination between center staff assessment and program planning, and that of specialized Health Service, IFSP, or IEP teams, child care providers need to make an active decision to become a part of the team process. This, in turn, requires that child care providers have basic knowledge about the early intervention team process and roles of the various disciplines and agencies involved, develop skills to practice effective team process including decision making and communication skills, and designate methods to maintain two-way communication between center staff and other team members.

Effective early intervention requires cooperation among specialists from multiple disciplines and involves shared information, strategies, and techniques. Depending on the needs of the child and family, an early intervention team could include:

Family Members - Family members bring the unique perspective of priority interests or concerns about the "whole child" to the team. Family members are also the people who spend the most time with a child and are, therefore, generally most knowledgeable about the child's functional strengths and needs. Parents are the only ones who have the right to choose among options for their child.

Educators - Early childhood educators and primary education teachers are specialized in facilitating the learning and development of young children. Once children enter a regularly scheduled child care or education program, early childhood educators or teachers are second only to family members in providing consistency of interaction with the child. While other team members may see a child on a weekly, monthly, or annual basis, child care providers and teachers are with the child much more frequently. As with other specialists, early childhood educators are skilled in child assessment methodologies.

Early Intervention Specialists - The function of an early intervention specialist is to teach child development strategies to family members in order to facilitate the child's growth and development, and to help facilitate transition between programs or integration into home, school, and other community activities. Other names for an early intervention specialist include: child development specialist, special education consultant, family educator, family-home trainer, and family support specialist.

Physicians and other medical personnel - While every child should be seeing a pediatrician regularly, children with special medical needs may be seeing a variety of other medical specialists as well. In general, physicians are responsible for diagnosis and treatment of health problems. *Otologists* specialize in physical disorders concerning the ear, nose, and throat. *Cardiologists* specialize in disorders related to the heart. *Neurologists* specialize in disorders related to the nervous system. *Psychiatrists* specialize in mental, emotional, or behavioral disorders. *Surgeons* specialize in surgical techniques to improve physical functioning, or remediate deformity. *Pediatric Nurse Practitioners* are registered nurses with additional specialized training and certification/licensure which allows them to carry-out a variety of medical procedures under supervision of a physician. *Public Health Nurses* are registered nurses who work in the community caring for persons in their homes or a community setting.

Therapists - In general, therapists focus on assessment and rehabilitation to improve developmental skills or abilities. *Audiologists* specialize in hearing. *Occupational therapists* specialize in fine motor skills, oral motor skills, and activities of daily living. *Physical Therapists* specialize in large motor function related to coordination, balance, muscle strength, endurance, range of motion, and mobility. *Psychologists* specialize in behavioral, social or emotional disorders. *Speech therapists* specialize in communication disorders concerning voice, articulation, oral motor skills, language and hearing.

Other Team Members - The full range of possible team members may include a variety of other individuals. For example social workers, nutritionists, or baby-sitters may participate as team members.

B. Role of The Early Intervention Team - The three early intervention team models most often discussed are defined below:

In a *multidisciplinary team*, individual team members may meet together to discuss child or family needs, but will generally provide assessment, intervention, and follow-up services independently

In a *transdiciplinary team*, members share knowledge and skills between members, so that one or two team members can implement assessment, intervention, or follow-up strategies using techniques learned from other specialists on the team.

In an *interdisciplinary team*, members conduct independent assessments, meet to determine a coordinated service plan, individually implement interventions, and then meet again to report progress coordinate and monitor the program and evaluate outcomes.

While a variety of models for providing services have been tried, the interdisciplinary team process now appears to be the type generally preferred in health service delivery to children and their families, while the transdisciplinary model is generally preferred in early childhood education programs.

Key to effective team process is coordination. Regardless of the specific model being used, a *service coordinator* or *case manager* should be assigned to facilitate the team process. The designated service coordinator may be any team member with sufficient knowledge of the family and child to do an effective job in coordinating team efforts. Various functional roles of a service coordinator include: information gathering, team building, service coordination, monitoring and evaluating team efforts, problem solving and negotiating, and child advocacy.

The four general tasks of early intervention teams are: (a) evaluation and assessment, (b) program planning and decision making, (c) arranging for provision of intervention services, and (d) continuing program monitoring and follow-up evaluation. These tasks are briefly summarized below (Golin and Ducanis, 1981).

Evaluation and Assessment -

The term evaluation is generally used to refer to comprehensive clinical diagnosis and identification of specific developmental limitations. The evaluation team may include a variety of medical and allied health specialists (e.g. physical therapists, occupational therapists, language pathologists, etc.), chosen according to the child's status at the time of referral.

The primary purpose of assessment is to provide the early intervention team with information to assist them in making decisions that will enhance the child's education and development. Assessment methods must be nondiscriminatory and should include both subjective and objective information about child behavior and development. Assessment data needs to be collected from a variety of individuals providing direct child care services to the child.

Each team member is responsible for gathering, interpreting, and reporting specific information about the child. Assessment information is shared with the team through written and verbal presentation. Often there is overlap in the areas team members assess. Some error in measurement will always be assumed due to possible observer error, instrument error, measurement error, or variation in the individual being assessed. Any information which has not been directly observed, is inferred, and should be stated clearly as "interpretation" rather than as a "fact." An advantage of team process is that it allows an opportunity to identify and correct misinterpretations of individual team members.

Members may collect different data on similar developmental areas. It is a team function to reinterpret and integrate the individual disciplinary assessments into a summary representing the "whole child." Interpretation of data collected by individual team members is a group function and team members should take care that premature conclusions are not generated during the assessment process. The assessment and information gathering process is ongoing, however, and as new information is provided, prior decisions or conclusions will need to be modified by the team.

Decision Making

Once information has been collected through the evaluation and assessment process, the team will begin to make decisions about what intervention strategies would be helpful to the child. As the decision making process evolves, prior decisions affecting the child's development will be reviewed in relation to the child's current status, and the families current priorities. This information will be used to guide further decision making.

Two key criteria for family-centered early intervention decision making are *alternatives* and *parent choice*. Team members must have enough information to generate alternative intervention strategies, allowing parents (in partnership with the team members) the opportunity to choose which approach will best meet the needs and priorities of the child and family. Without alternatives and choice there is no opportunity to make decisions -- the process is prescriptive rather than family-centered.

Differences in professional and personal backgrounds can be expected to lead to certain disagreements. One role of the team leader is to create an atmosphere where a variety of alternatives can be generated, and courses of action freely evaluated. Opportunities exist during the team meeting to discuss pros and cons of various alternatives, and may lead to better solutions. Because most decisions present an element of risk for the decision maker, chronic avoidance of decision making may be seen as a way of avoiding risk. There is some research to suggest, however, that team decisions may reflect a greater willingness to take risks than decisions reached by individuals.

Intervention

Once decisions about intervention strategy have been made by the team, plans to carry out the decisions must be made and implemented. Strategies used in implementing early intervention goals and objectives will be influenced by a variety of factors including: the specific needs of the child; resource availability; parent preference and experience; professional preference and experience; and administrative regulations.

There must be team coordination of the services offered to the child and family in order to avoid fragmented or conflicting services, or service replication. The team approach, however, does not automatically guarantee integrated services or quality of services. As discussed previously, a service coordinator on the team needs to be consistently responsible for monitoring team process including intervention strategies, in order to promote provision of coordinated, integrated, and quality services for each child.

Monitoring and Evaluation

Once intervention strategies have been implemented, periodic monitoring and evaluation must occur in order to revise the child's intervention program. Team members are always receiving feedback information related to the effectiveness of planned interventions. Evaluation and monitoring of the outcomes of the team process are ongoing. A minimum time frame for formal review of an early intervention plan is every six months, however, more frequent reviews of specific objectives may be called for given the rapid pace of early child development.

C. Using Effective Team Process Skills To Maintain Positive Relationships Among Team Members - Willingness to accept advice and share knowledge and information among team members are essential to effective team process. Team process involves building on the knowledge and skills of each individual team member, in order to arrive at a syntheses of information. The collective synthesis of information guides further team process of cooperative planning and decision making.

Collaborative team-work is not always easy for professionals. Generally, professionals practice their trade with a high degree of independence or autonomy. Coming together to work collectively requires team members to give-up a certain degree of autonomy, to the group process. Group process results in new relationships among professionals which include: a) shared "turf", b) interdependence, c) shared responsibility and commitment, and d) expanded communication networks (Pappas & Nicholson, 1985).

A Format for Decision Making

The primary goal of early intervention teams is to devise and implement a plan of early intervention to expand on a child's developmental strengths and provide habilitative intervention to lessen developmental deficits. The nature of early intervention team tasks suggests that, in general, teamwork will occur in a "problem solving" context. Following a problem-solving format will help team members focus on the issues, and avoid unnecessary digressions and/or conflict.

There are many examples of problem solving or decision making formats in the literature. The basic steps include:

1. Identification of the need or problem .
2. Gaining a clear understanding of the need or problem.
3. Collecting additional information and assessment data .
4. Analysis of the need or problem based on collected data.
5. Development of a conclusion/summary that integrates data.
6. Planning appropriate action or intervention strategies to address need or problem resolution (Berger,1987).

A more detailed description of a problem-solving approach,called "family needs solving", was discussed in the Unit III: Working With Parents (pp. 37-47).

Common Pitfalls of Group Process

Common pitfalls of team process, along with suggestions for evaluating and improving teams' effectiveness, have been developed by Indiana University Developmental Training Center (Pappas & Nicholson, 1985). A summary of some of the problems or pitfalls, follows.

Common group pitfalls in the area of group tasks, include:

- Lack of preparation for team meetings
- No sense of direction
- Frequent digressions
- Participation of little or no substance
- Rejection of ideas
- Eagerness to accept premature solutions
- Lack of ethical sensitivity
- Member dominance in participation
- Failure to consider consequences of "solutions"
- Failure to document or act on group decisions

Common pitfalls in the area of interpersonal dynamics, include:

- Personality conflicts
- Undue influence because of status or relationships
- Inability to separate the person from the issue
- Unwillingness to contribute
- Group cohesion valued more than task
- Pressure for uniformity
- Unwillingness to accept or negotiate outcome

Ways to Improve Group Process

A list of recommendations to enhance group process, adapted from the Indiana Group Effectiveness Evaluation, includes the following principles of effective team process:

1. *Information Principles*
   - Have enough information on which to base decisions.
   - Draw on reliable sources of information, and check the reliability of sources.
   - Identify and try to resolve conflicting information.
   - Reassess team positions when new or conflicting information is introduced.
   - Seek additional information to fill "knowledge gaps", rather than neglecting issues because of lack of information or knowledge.
   - Use information gathered to generate alternate solutions prior to decision making.
   - Discuss reasons (e.g. criteria) for accepting and reasons for rejecting possible solutions prior to selecting alternatives.
   - Search for additional alternatives before making premature solutions
2. *Procedural Principles*
   - Remain goal directed.
   - Define the group task clearly and objectively.
   - Take the time necessary to assure that all team members understand the purpose.
   - Develop an agenda.
   - Follow the agenda.
   - Do not be overly constricted by the agenda.
   - Effectively counteract diversions from the agenda.
   - Clarify where the group stands on each issue before moving on to another issue.
   - Define unclear terms, and achieve team agreement on how terms are used.
3. *Interpersonal Principles*
   - Take time to discuss and resolve interpersonal conflicts when they arise.
   - Keep conflict resolution focused on issues rather than personalities.

- Avoid (and counteract) any group member overly influencing group proceedings or outcomes because of their position in the group or relationships with other group members.
- Avoid (and counteract) any group member allowing personal feelings toward others to affect their judgement on issues.
- Draw members who appear to be withdrawn from the group, back into the team process.
- Help group members feel comfortable in expressing minority opinions.
- Avoid allowing pressure for agreement or task completion to in any way limit the free exchange of information and ideas.

4. *Ethical Principles*
   - Show proper concern for the people whom team decisions will affect.
   - Remain responsible and professional during team meetings.
   - Check that all information and positions have been accurately documented.
   - Be sensitive to the different values of group members.
   - Avoid actions that threaten any participant's sense of self worth.

D. Maintaining Communication Between Center Staff And Other Team Members - Written documentation, is an important aspect of team process. As each team member carries out his/her assessment and intervention activities between team meetings, critical information needed for group decision making can be lost unless some type of record-keeping strategy is in place.

Regardless of the format used for this purpose, team members will need to have some formalized way of:

(a) maintaining a current list of active team members,
(b) authorizing release of information between team members,
(c) recording an individualized action plan [e.g., Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), Individualized Habilitation Plan (IHP)], and
(d) translating intervention objectives into the general activities of early childhood, to facilitate intervention strategies being carried out in the child's home or early childhood program.

The sample forms included in *Appendix K* represent examples of information sharing strategies used by various programs to facilitate the information exchange process. Additional information on translating intervention goals and objectives into regular early childhood activities will be provided in the next unit, *Implementing Curriculum in Integrated Early*

Childhood Settings. The following section discusses the sequence of team activities involved in provision of early intervention.

II. Sequence of the Early Intervention Process

A. *Early Screening and Identification* - The first step in providing an appropriate early intervention program of services for children with developmental disabilities is identification. PL94-142 requires education agencies to conduct *child find* efforts in order to identify, refer, and evaluate individuals with disabilities ages 0 - 21 years of age, to assure that they receive an appropriate educational program (Davis, 1986). Many child care agencies may already be receiving information from their local school district regarding child find activities. It is important that each child care provider be informed about these local efforts and that each child care center actively participate. To find out more about local child find efforts, child care center staff should contact their local school district 's office of special services.

Effective participation in child find efforts requires child care providers to (a) know the difference between normative and atypical development and (b) understand and practice systematic observation and recording procedures within the early childhood setting on a regular basis. Due to their in-depth working knowledge about age-appropriate behavior and development, child care providers may be the first to notice that a child has some type of developmental delay, which signals a need for more thorough assessment. Often early identification will involve *developmental screening* activities. Screening is a process of identifying children who are experiencing some degree of delayed development, who may be in need of special assistance. Children who are identified through a screening process are then generally referred to special education or health systems for comprehensive assessment, or diagnosis (Davis, 1986.)

Following are some guidelines for selecting appropriate screening instruments, adapted from Cook, Tessier, and Ambruster (1987.):

1) Always check to see what qualifications are needed to administer screening or assessment instruments; some require special certification or specialized training.
2) Check to see that the instrument is considered both reliable (e.g.measures factors consistently) and valid (e.g. is screening for the factors it says it is).

3) Check to see that the children who participated in reliability and validity tests of the instrument are similar to the children in your center (e.g. includes members of minority groups and children with specific disabilities).
4) Make sure that the cost and time factors for conducting the screening meet with your center resource criteria.

Local school district offices of special education may be contacted to obtain a list of accepted screening instruments. Many of these may already be familiar to early child care providers. Every child care provider who is involved in screening children should be thoroughly familiar with the procedures for administering the instrument being used. If formal inservice training is not possible, the best way to learn how to use a new instrument is: (a) read the training manual to learn how to administer the screening instrument, (b) practice using the materials to administer each part of the instrument, and (c) practice administering the instrument to other staff members, prior to using it with children.

Because screening is a process for identifying children with developmental delay, a child who has already been identified to have a disability would not need to be involved in the screening process. Center based assessments will be needed, however, in order to develop appropriate individualized service plans. Likewise, a child who exhibits mild delay on one or two items on a screening instrument would not need to be referred for comprehensive assessment by a special education or health specialist. In this case the child's progress should be monitored and curriculum adapted as necessary to help the child develop the related skill. If after a period of time the delay continues, the center staff should talk with the child's parents, and may want to consult with an appropriate specialist to discuss additional intervention strategies.

B. Referral and Comprehensive Assessment -

Making a referral -As noted above, when child care providers are serving children with an identified disability or suspected disability, a referral should be made to the local school district office of special services, in accordance with established child find procedures. Note that parents should always be informed, both about a child care center's participation in child find efforts and the specific reasons why the child care provider is making the referral. This process requires that child care providers be fully informed about local child find procedures and have clear records outlining the specific developmental indicators or behaviors that suggest a need for referral.

Vague, general descriptions of a child's deviant development or behavior is not sufficient for parents, education agencies, or future assessment and program planning activities.

If the school system decides that the child care center's or their own screening activity indicates a need for more thorough assessment, the district staff will (a) arrange for an Admissions and Release Committee (ARC) for children ages three or older, or, (b) write a report describing what type of follow-up assessment or services are recommended , for children younger than three years of age. If screening or assessment indicates that a child is not eligible for special education services the district staff should write a report explaining their decision and recommend alternate community services that may be of assistance to the child and family.

It is important for children to be referred and, if indicated receive a thorough assessment by area educational agency staff, as early as possible. These comprehensive assessments are conducted by certified specialists who are approved to make diagnostic decisions. Assessment results are used by the ARC to determine the best educational placement for the child and to develop a child's individualized education plan (IEP.)

Due to complex and busy service schedules, education agency staff may not be able to respond to a center's referral as quickly as a child's parents and child care providers would like. In these situations, it is perfectly acceptable for parents and the child care staff to conduct a center based assessment to assist them in planning appropriate center based services, while waiting for the school district to respond to the referral request.

Conducting A Center Based Assessment -The purpose of conducting a center based assessment is to collect the information needed by child care staff to plan an appropriate early childhood education program. By definition, a developmentally appropriate child care program will not only provide age-appropriate activities for children who are acquiring skills according to normative developmental guidelines, but also provide targeted activities for children experiencing some type of developmental delay, to help these children develop the needed functional skills. Conducting center based assessment is the mechanism by which child care staff identify the skills a child needs to work on, and is the starting point for planning program activities. Conducting center based assessments with children who, through screening activities, have been identified to have some developmental delay should become a standard component of quality developmental child care programs.

The following guidelines for conducting assessments in an integrated early childhood setting are adapted from Baily and Wolery (1984).

1) Selecting an appropriate assessment instrument

Selecting an appropriate assessment instrument for young children with disabilities involves a number of considerations, including:

1. Are the skill areas included within broad domains (e.g physical, cognitive, socioemotional, language, motor, self-help) divided into meaningful subunits of behavior?
2. Is the age range addressed appropriate for the child being assessed?
3. Are activities suggested for training skills included with the assessment package?
4. Does the instrument and/or activities include suggested adaptations for children with sensory or motor impairments?

The Carolina Curriculum for Handicapped Infants and Infants at Risk (Johnson-Martin, et al, 1986) and The Carolina Curriculum for Preschoolers with Special Needs (Johnson-Martin, et al, 1990) are examples of curriculum linked instruments which include adaptation for children who are blind or deaf. The Hawaii Early Learning Profile (1988), and Help For Special Preschoolers (1987) are two other curriculum linked assessment that should be considered for use in early childhood settings. Once again, additional information about accepted assessment instruments should be readily available from local education agencies or other early intervention resources.

2) Conducting Assessments

Most of the following recommendations will apply to all early childhood assessment situations. These, however, become particularly important when conducting assessments with a young child with disabilities, due to the child's physical or cognitive limitation.

1. Assessment situations should be non-threatening. Whenever possible, it is recommended that the assessment take place in the child's own child care setting, and be conducted by familiar child care providers. Having parents present may help the child to feel more secure, and can help to determine optimal performance levels.

2. Multiple assessments should be conducted over several days. In order to provide an accurate reading of a child's abilities, it is important that assessment information be collected when a child is responsive and alert. All young children demonstrate rapid changes in levels of alertness, which may be magnified by a child's particular physical condition or type of disability.
3. The child needs to remain motivated in order to perform well. Assessment periods should be no more than 30 - 45 minutes in length, and should be terminated sooner if the child care provider thinks that the child is no longer performing at his or her ability level due to fatigue or other limiting factors. Using interesting materials and a game-like format will help increase and maintain optimal attention and performance. Some children may require special reinforcement for trying or for correct responses.
4. Assessment items may need to be modified for certain children. While modifying test procedures will invalidate measurement results, if the purpose of assessment is to determine the child's current level of functioning *for program planning purposes* it is recommended. Children with sensory or motor impairments may be able to accomplish a task if the materials or activities are modified to accommodate their performance capabilities. For example a test item that requires a child to *look at pictures and point to the picture* that is an apple, may be accomplished by a child who is blind if given similar objects and selecting the apple from other objects. Children with mental retardation may not be able to perform a task independently, but could if given a model or if the instructions were simplified and repeated.
5. Accurate results may require interdisciplinary assessment. With children having severe or multiple disabilities, the only way accurate information may be able to be obtained is through an assessment process involving appropriate specialists. Often initial assessment by child care staff can help staff to identify areas or assessment items that will require additional specialized assessment. For example a child who is blind may be able to perform a number of assessment activities that do not require visual acuity for their performance (i.e. stacking three cubes.) A vision consultant may be brought in to assist staff in assessing those areas that do require vision or helping staff to design alternate assessment strategies which measure the same functional skill using different tasks.
6. Involving parents in the process helps insure accuracy. While a particular child care provider will have limited experience with a

given child, parents have been interacting with the child since birth. Children with various disabilities may develop atypical adaptive skills used to interact within their environment. Parents are likely to be familiar with cues and reinforcement strategies that will enable the child to complete a task that child care providers have not been successful with. For example a parent might know that wrapping a rubber band around a crayon helps their child to hold the crayon more securely, which may assist the child in completing drawing tasks on an assessment instrument.

C. Writing Functional Goals and Objectives - After the assessment is complete, the next step is specifying short and long term objectives which describe the skills that the child is to learn. In general it is a good idea to talk with parents and, together, select targeted skills that will be most useful for increasing the child's participation and independence. Once these general targets have been selected functional goals and objectives need to be written.

A *functional goal* is a broad statement of what a teacher intends to teach children. For example, to demonstrate personal responsibility, to develop self-help skills, or to improve eye-hand coordination.

Functional objectives are specific statements describing what children will learn to do, and which describe the learning situation precisely and accurately. Beginning with well written objectives allows teachers to monitor learning progress. Writing functional objectives is a matter of clearly stating in written form:

a) what the teacher will do and the methods or materials used for carrying out the objective;
b) what the learner will do when the objective is achieved;
c) the conditions under which the learner must perform the objective in order to have achieved the learning; and
d) the number of trials and time period for achieving the objective.

T*erminal objectives* represent the most difficult task within a skill sequence on a developmental assessment instrument, appropriate to a child's developmental level. For example for the self-help skill of dressing, the terminal (e.g , most difficult) skill is often zipping a front zipper. *En route behaviors* refer to a sequence of behaviors needed in order to achieve a terminal objective. The objective "grasping small objects between thumb and forefinger", might be one en route behavior needed for the task of "zipping zippers."

A simple worksheet for writing functional objectives is illustrated below. See *Appendix L* for a blank worksheet.

What the Teacher Will Do:	**What the Learner Will Do:**	**Conditions for Achieving the Objective:**	**Target Criteria and Date for Achieving the Objective:**
When given the signal for clean up time (i.e ,teacher says clean up time while blinking the lights), ...	Johnny will begin to help clean up the area he has been playing in...	within 30 seconds of the signal, following a verbal prompt by a teacher...	at least four of five times (80%), by November 19, 1990.
When the teacher says it is time to brush her teeth following lunch, ...	Susan will independently go to the sink and begin teeth brushing...	completing four of the eight task analyzed steps correctly and independently...	at least four of five times, by October 15, 1990.

D. Planning an Instructional Sequence

A *task analysis* process is often used to analyze and describe the sequence of en route behaviors needed to reach a terminal objective. Task analysis is accomplished by considering the behavior demonstrated in a terminal objective and, working backwards, writing down each preceding behavior until the beginning of a the particular behavior sequence is reached. Many different task analyses may be developed for any given skill.

Once a task analysis has been completed, the steps are then generally restated in the sequence in which skills will be taught. The term *foreword chaining* refers to teaching a skill sequence from first to last step, while the term *backward chaining* refers to teaching a skill from last to first step. An example of a possible task analysis for the skill of zipping up a jacket, using a backward chaining sequence, is illustrated in the following outline.

Terminal Objective: Wearing her spring jacket, Judy will zip up her zipper independently, without adult assistance, before going home for the day, four of five days, by June 30, 1990.

En route objectives for Judy:

1. Is wearing jacket with zipper zipped, when ready to go home.
2. Given help to start zipping, holds bottom of jacket with left hand and finishes zipping jacket with right hand, independently.
3. Given help inserting right into left part of zipper, holds bottom of jacket with left hand, and zips jacket independently.
4. Puts right into left part of zipper independently, holds jacket at bottom and zips up zipper.

A decision to use backward chaining in this sequence is useful for building a sense of accomplishment. As more difficult steps are being taught, Judy can be given positive recognition for having her jacket on and zipped by the time she leaves for the day. As anyone who has zipped a jacket knows, the most difficult task is getting the two pieces of the zipper aligned, and then securely holding these ends together as the zipper is zipped!

By the time goals and objectives have been written, and the instructional sequence determined, curriculum development is well on its way. What remains is how the goals and objectives will be integrated within the ongoing routines and activities of the center, so that a child is working on skills throughout the day during regular early childhood activities.

UNIT V: IMPLEMENTING INTEGRATED CURRICULUM IN EARLY CHILDHOOD PROGRAMS

A. Procedures for Translating Functional Goals and Objectives Into Curriculum Plans

In general, the task of child care providers is to *plan and implement appropriate curriculum,* to help children meet program goals and objectives. A major difference between planning and implementing curriculum for children without disabilities and children with disabilities is -- **INDIVIDUALIZATION.**

In integrated child care settings, the child care provider's task is to plan and implement activities which incorporate (or integrate) the individualized goals and objectives identified for children with special needs into the generic/regular child care program curriculum.

Prerequisites for Devising Effective Curriculum Plans

The basic prerequisites for devising effective curriculum plans for children with disabilities in integrated child care settings include:

1. Knowledge of early-childhood development and methods for curriculum planning and implementation in generic early child care settings.

- Write weekly/daily classroom schedules that specify age-appropriate activities for routine time periods and activity areas.
- Provide for a range of developmental skill levels within activities.
- Observe how children interact within the arranged environment, providing individual assistance or environmental adaptations as needed to encourage optimal skill development.
- Provide opportunities for children to engage in increasingly complex activities, as they master prerequisite basic skills.

2. Consultation with the child's IEP/IFSP members (e.g., parents and specialists).

- Identify individualized objectives for children with special needs.

- Determine/learn specialized "interventions" needed to help children to meet specialized objectives, including procedures for monitoring progress.

- Get written suggestions on times/activities for implementing specialized "interventions" within your classroom environment/schedule.

- Get a written list of activities that a child should not participate in (if any), because of physical or health risks.

- Develop written emergency procedures, if needed.

3 *Personal creativity.*

- Develop a procedure for record-keeping that matches your organizational needs. Include information on: consultations with parents and IEP/IFSP team members; long-term and short-term objectives; specialized procedures; time lines for implementation and monitoring; individual activity plans; and written records of monitoring/assessment activities.

- Continue to expand your reservoir of activities that assist children with disabilities to be active participants in regular, age-appropriate, early-childhood activities.

See *Appendix M*: Sample Planning Curriculum Forms, for additional ideas.

Specialized Curriculum

Just as a variety of curriculum models have been developed in regular early childhood education, there are a variety of curricula that have been developed for special education. While quality curriculum for integrated child care relies first on a quality early childhood program, materials developed for special education are valuable resources.

Specialized curriculum often have coordinated assessment and curriculum units, and include adaptive suggestions for children with particular special needs. These curriculum frequently state objectives using functional goal and objective statements. The sequence of instructional strategies is generally more detailed than is true for generic early childhood curriculum, to accommodate specialized learning styles of children with particular disabilities. By selecting specialized early childhood curriculum, that generally address the particular needs of children with disabilities, early childhood educators can add to their resource of ideas and strategies to appropriately meet children's individual needs.

Additional information about curriculum and general instructional strategies can be obtained by contacting local special education programs or contacting The Council for Exceptional Children's Division of Early Childhood (CEC/DEC). Many child care providers may not be receiving information on materials particularly helpful in working with children with special needs. The CEC/DEC is a national organization, specifically concerned with education of children with special needs. There address is:

The Council for Exceptional Children
The Division of Early Childhood (DEC)
1920 Association Drive
Reston, VA. 22091
(703)620-3660

Several curricula that may be helpful to use in integrated child care programs are included under the category *Curriculum* in the *Appendix N* Project Lexington Resource Directory.

B. Basic Special Education Techniques to Enhance Learning Functional Skills

Learning is an invisible process, inferred by observing a person perform various tasks; increased ability or performance is inferred from observing behavior (Baily and Wolery, 1984.) We know that many conditions such as a persons, health, environment or level of motivation affect behavior, and these variables also influence learning.

Regular early childhood programs provide children the opportunity to learn through play the "work" of early childhood. In regular early childhood programs, children have opportunities to model or imitate same-age peer interaction, to negotiate differences and challenges, to practice needed communication skills, and to make choices. Early social skills are learned through meaningful interactions with other children. In these situations. children can learn how to share, help, cooperate, work, and relax together during their normal activities of childhood.

Within a rich early child care setting many children will be learning many of these behaviors in what *appears* to be a spontaneous way; that is, without direct instruction. For example, given the opportunity (and motivation) to play in a block area, most children will progress from arranging blocks randomly on the floor to constructing large multidimensional structures. While early childhood educators generally do not teach block building, in fact, behavioral principles (such as reinforcement, modeling, and behavioral prompting) are at work in all learning situations. Furthermore it has been determined that there are at least three phases of learning which have implications for planning instructional curriculum (Baily and Wolery, 1984).

Early childhood educators working with children having disabilities have found that direct instruction using these various principles can help children to develop certain skills, that they are not developing "on their own". Direct instruction, however, should not be confused with one - on - one instruction. All of the strategies reviewed in the following discussion, (adapted from Baily and Wolery, 1984) can be used in regular small or large group early childhood activities.

PHASE 1: The first phase in learning is *acquisition.*-

The acquisition phase of learning is most often associated with the concept of "teaching". It is during this phase that we learn how to do a task - the outcome measure being accuracy of performance. This phase requires that the learner be motivated to become involved in the learning activity and receive enough positive feed back from the experience to continue involvement until mastering the task. Motivators may include antecedent events such as how the task is presented or the materials used. If positive reinforcement occurs once the task is tryed, this also becomes a motivator.

Antecedent Events

Additional considerations to keep in mind when planning and implementing curriculum for children with disabilities (or without), related to antecedent events are listed below:

(a) Avoid attempting to teach skills that are too complex - break complicated skills into smaller steps (e.g. task analysis).

(b) Determine whether it will be more meaningful or rewarding for the child to use forward or backward chaining in teaching a skill sequence.

(c) Help children to direct their attention to relevant aspects of the task being learned by using verbal cues, physical prompts or by removing external distractors.

(d) When giving directions keep them brief, but specific. For example say: Touch the red block - rather than saying: Show me the red one.

(e) Adjust the rate of instruction to fit the child's performance mode; some children will take longer to respond, or need additional repetitions of a direction prior to responding, than others.

Direct Teacher Assistance

When direct teacher assistance is needed to help a child acquire a skill, keep the following strategies in mind:

(a) Use the following *errorless learning procedures* to give the child every opportunity to succeed:

- Stimulus shaping- this technique involves manipulating components of the task to help secure success. Examples of stimulus shaping used in early childhood programs on a regular basis include using fat paint brushes and markers, rather than skinny ones; placing pictures of toys on the shelves where the toy belongs; or exaggerated body movements to illustrate and practice the concepts of big and small, happy and sad, etc. As children become more accurate in performing new skills, stimulus shaping (or manipulating components of the activity) can be reduced, so that eventually the child will be performing the task (e.g. in our examples painting or drawing, putting toys back where they belong, and contrasting attributes) without these procedures.

- Stimulus fading - this technique involves highlighting the correct response, so that the child is more likely to choose the correct answer, then gradually fading the cues that suggest the correct response to the child. Examples of stimulus fading could include highlighting the dimensions of position, color, size, or surface texture of the correct item when asking a child to choose the correct object from a series. In early childhood language activities this technique is used frequently; for example when a picture of an apple is associated with the letter A, using sandpaper letters to teach the alphabet, or writing the word for a color on the color card.

- Response shaping - this technique involves rewarding successive approximations of a target behavior, and therefore involves controlling consequences rather than antecedents related to learning behavior. Parents and child care providers consistently use this technique as they encourage their infants and toddlers first steps and first words. A good example of this technique in early childhood programs is the, now commonly accepted, practice involved in whole language experience. According to this method, children are encouraged to make active attempts to read and write independently without constant reminders of "the right way" to read or write a sentence. (Both stimulus shaping and stimulus fading are involved in the use of "Big Books" used to teach correct word and sentence structure.)

(b) Sometimes children will need direct teacher assistance to learn new skills. The basic *direct teaching techniques* involve the use of extrastimulus prompts (e.g. something in addition to providing an effective stimulus). When direct teaching is needed, keep the following suggestion in mind:

- Examples of extrastimulus prompts include verbal cues, gestures, models, partial physical prompts, and full physical prompts.

- Prompts should be sufficient for the child to accomplish the correct behavior in order to receive reinforcement for performing the behavior.

- Prompts should be faded as quickly as possible, to promote independence in performing tasks.

- Using a system of least to most prompts, or most to least prompts, is helpful for controlling progressive learning. These techniques use a response "ladder" or hierarchy. Using a system of least to most prompts begins with the least intrusive type of prompt (e.g. verbal cues) and could progress to the most intrusive (e.g. full physical prompts) if needed in order for the child to accomplish the task, and thus be reinforced for doing so. This is the most common direct teaching method, and is useful for teaching almost any new cognitively based skill in early childhood settings. When learning new motor skills, however, a system of most to least prompts may be more helpful. This technique begins with a full physical manipulation (such as holding your hand over the child's to hold a paint brush and paint) and progresses downward to partial physical manipulations, modeling, gestures, verbal cues - ending with a child performing a task independently.

- Use graduated guidance once the child has learned the basic steps of a task, to help the child accomplish the task. This technique involves (a) beginning each task providing the level of assistance needed for the child to accomplish the task; (b) immediately fading the assistance once the child begins to do the task; (c) if the child stops doing the task, immediately providing the level of assistance to help the child begin the task again, and then immediately fade the assistance; (d) redirect the child if he or she begins to move in the wrong direction; (e) reward the child for any part of the task that he or she completes independently; and (f) withhold rewards if the child is resisting assistance at the completion of the task.

(c) Children will make errors, and there are a variety of *techniques to respond to children's errors* . Some of these are listed below:

- Random Errors - These errors occur when a child has learned a new skill. The child will "get it right" most of the time, but occasionally errs, without a clear pattern of errors being observed. A well known sample of random error occurs during toilet training, when most of the time the child is "dry" but, sometimes has "accidents". Early childhood educators and parents can help children overcome random errors by changing the consequences, or type of reinforcement, for the task. For example, when a child is "dry" fairly regularly, parents may increase the incentives for remaining dry by using "big girl or boy pants" to reward being dry. To reduce random error reinforcers can be changed, the schedule of reinforcement can be changed, reinforcement can be given when fewer errors are made, or for a given number of correct responses.

- Errors Due to Noncompliance - In contrast to random errors, noncompliance errors are intentional. These errors can be distinguished from random errors because there is generally a pattern to the error (i.e. a toddler soiling a diaper when Mom is feeding the new baby.) Reducing noncompliance errors also involves changing the consequences and altering reinforcement. In addition to the examples listed above for random errors, it may also be necessary to add consequences for the error (i.e. Mom telling the child that she can't do anything about the wet diaper now because she is feeding the baby, for the toddler to get a clean diaper, and that she will take care of it once she is through). Most childhood noncompliance errors occur either because a child does not feel that they are getting enough attention (e.g. the behavior is punishing the adult), or because a child does not want to do whatever the task is (e.g. communicates the message that the child is feeling a lack of control, or is bored). It may, therefore, also be helpful to consider altering antecedents to encourage correct responses (e.g. Mom planning to spend one-on-one special time with the toddler before feeding the baby and/or involving the toddler in the feeding time by having him or her choose special music to play or telling the baby a story.)

- Systematic Errors - These errors generally become evident as a child is in the process of learning a new skill, and occur because the child has developed a faulty rule or strategy to guide their behavior. Systematic errors can be identified by their consistency. We all have made systematic errors in spelling. For example, adding an "s" to dog and cat works, but is not correct with mouse(s). Many systematic errors are difficult to detect, however, and may require some data collection to discover a pattern of error. Systematic errors can be eliminated by using errorless learning procedures and/or extrastimulus prompts.

- Errors Due to Unlearned Prerequisite Behaviors - These errors are common throughout early childhood; adults often assume children should know or do things that they do not have the background knowledge or experience to do. For example children need to learn how to "walk don't run indoors" or "sit and listen during circle time". The consistency and disruption in the skill sequence cues us that an error due to unlearned prerequisite behavior is occurring. The way to help children overcome this type of error is to teach the prerequisite behavior. In the above examples, the child may need to be taught the rule that "walking is for indoors and running is for outdoors," or the skill of "listening." The way to identify what prerequisite behavior needs to be taught is to: (a) task analyze the skill sequence involved in the "terminal objective, (b) identify the sub-skills the child needs to learn, and (c) teach the child these sub-skills."

PHASE 2: The Second Phase of learning is *fluency building*

Building fluency in a skill means that the skill can be accomplished with reasonable speed and/or for a reasonable length of time. To build fluency, requires practice. This is a time in learning when noncompliance errors may occur, because practice can be boring. Techniques to increase fluency involve presenting appropriate antecedents and reinforcement, similar to that used in the acquisition phase. Now, however, a child is rewarded for doing an activity more quickly or for a longer period of time, rather than as a condition of accuracy. Introducing a timer and a game of "beat the clock," (e.g.when rewards are given to a child for doing a task within a specified time or for a given length of time) can be effective during this phase of learning.

PHASE 3: The third phase of learning is *generalization.*

Generalization means that a behavior learned in one situation is performed in another. Four types of generalization may apply: (a) *across settings*, means that a skill taught in one setting is performed in another; (b) *across persons*, means that a skill taught by one person is performed when another requests it; (c) *across objects*, means that a skill learned with one object is performed with similar objects or tasks; and (d) *maintenance*, means that a skill learned during instruction continues to be performed over time, after instruction ends. It is important to remember that generalization does not just happen, particularly when working with children having some disabilities. Strategies to keep in mind to encourage generalization skills (with any child) include the following strategies:

- *Training sufficient exemplars* - This technique involves sequential training of a skill in different settings, with more than one person, or using several examples of similar tasks. It is very effective in promoting skill generalization, and research suggests that generalization will often occur after training with several exemplars is used. The significance of this technique for helping children to master functional skills, highlights the importance of working with parents and other members of a child's IFSP/IEP team so that skill training is consistent across a child's home, child care, and/or additional environments.

- *Best example theory of categorization* - Teaching techniques based on this theory use objects most representative of that object's category. For example, in teaching colors it is common to begin with red, yellow, and blue rather than magenta or lime green. This technique underlines the importance of considering a child's family and community setting in designing curriculum. For example, if most children in a center live in apartment buildings using a picture of a single family home to teach "house" (which means a building where people live) would be less meaningful to children than using a picture of an apartment building.

- *Programming common stimuli* - This technique says that the training setting should be as similar as possible to the setting in which the skill is to be performed (e.g. with similar furniture etc.). In teaching older adolescents and adults with disabilities the preferred setting for skill training is often the community site itself. Taking field trips, with activities extending back into the child care setting, is a familiar example of using this technique in early childhood programs.

- *Wise use of reinforcement* - While continuous reinforcement is needed during the acquisitions phase of learning, an intermittent schedule is needed during generalization. Intermittent levels of reinforcement include delaying reinforcement, reducing the reinforcement ratio, and using natural reinforcement systems rather than token systems.

Appendix N includes a listing of textbooks that can provide basic instruction in specialized techniques

C. Increasing the Type and Degree of Interaction Among Children With Disabilities and Their Nondisabled Peers.

Social development is the cornerstone of early childhood development. First during infancy in the development of trust through meaningful relationships with parents or other significant adults, and then in early childhood in developing relationships with peers, children learn the necessary adaptive skills for living within their community and culture. Research has clearly demonstrated the significance of preschool programs for helping children considered at-risk learn effective adaptive social skills.

Many administrators of fully integrated day care programs report that children with and without disabilities interact together quite naturally and that children accept each other regardless of ability level. Research generally suggests that frequent social interactions between children without disabilities and children with mild disabilities may occur without adult intervention. On the other hand, integration of young children with moderate to severe disabilities is not likely to result in frequent peer interactions, unless substantial efforts are made to promote these relationships (Baily and Wolery, 1984.)

A disability can affect a child's social development in a number of ways. Depending on the type of disability, children may exhibit delayed social development, lower rates of social behaviors, their appearance may cause other children to avoid social contact with them, or social initiations may be inhibited by physical or sensory impairment (Baily and Wolery, 1984.) Following are some of the strategies that Baily and Wolery suggest to help children develop social skills in integrated settings.

(a) *Assess children's level of social interaction.* Just as children learn other behaviors, children *learn* social skills. As with other types of skills planning effective intervention strategies for children with special needs in this area, should begin with an assessment of the child's current level of ability. A minimum assessment strategy should include making anecdotal observational records to determine a child's current level of social interaction during play (e.g. unoccupied, solitary play, onlooking, parallel play associative play, cooperative play, adult-directed behavior.) In addition, it may be helpful to use a checklist format to record types of interaction throughout the day.

(b) *Plan and arrange the environment to promote social interactions.* It is important that integrated child care programs provide an enriched variety of social toys and activities which encourage peer interaction. Social toys include classroom materials like dramatic play props, puppets, and rocking boats. Classroom activities encouraging socialization might include games like blind mans bluff, mural painting, or dramatic play. Some areas that promote solitary play can be enriched to encourage social play as well. An example of this is putting small cars, trucks and people in the block area, or incorporating dramatic play within the block area or playground. Materials that usually suggest individual play, such as peg boards or puzzles can also be used to encourage social play when presented in a game-like format.

(c) *Involve peers in intervention strategies.* Use of peer models or peer "agents" are particularly useful strategies to increase peer socialization. Both strategies involve pairing a child without disabilities with a child with disabilities, and both require the child without disabilities to be trained in particular skills. Peer modeling refers to peers intentionally modeling specific social skills such as sharing or how to initiate play activities. The term peer agent generally refers to teaching nondisabled peers how to help teach certain skills to a peer with a disability. An example of peer modeling would be if Karen (with a disability) needs to develop the skill sharing, Alex (without a disability) would be taught the process of sharing, asked to demonstrate sharing with a third child, be reinforced for doing so by the teacher who would also direct Karen's attention to Alex sharing. The teacher would take every opportunity to reinforce and point out sharing behaviors of children to Karen, and of course provide reinforcement to Karen when she engaged in sharing. Examples of situations where peers could be trained to be teaching agents might include helping a child learn to name objects, how to say please and thank you, or how to ride a "big wheels". In either case, it is extremely important to select peer models or agents who are willing to participate, who show caring and patient behavior, and who enjoy learning the steps involved in modeling or teaching a skill.

(d) *Use direct instruction and reinforcement to teach specific social skills.* Direct teaching of specific skills such as smiling, sharing, or imitation is also possible. As with any skill chosen for direct skill instruction, it is important that the social skill is sufficiently important for the child to learn in order to help the child more fully participate in his or her environment (e.g. chosen selectively). Direct instruction is not effective when it occurs in a haphazard manner, particularly when teaching abstract or complex behaviors like "sharing ". General guidelines for the direct teaching of social behavior include: (a) reinforcing the social behavior whenever it occurs; (b) modeling the appropriate social skill; (c) prompting the skill during normal play situations; and (d) practicing the skill through role play.

If child care providers find that lack of peer interaction is an issue between children with disabilities and their nondisabled peers, a method for promoting social interaction has been developed in curriculum format by Odom, Kohler, and Strain from the University of Pittsburgh. The method uses direct teaching of specific "social bids" to peer tutors, who then systematically promote peer interactions with their peers These social bids include the following categories: a) play organizers - "Let's play ball", b) shares - "May I play with the blocks with you?" or "here is a block; want to play with me?", and c) physical assists - reaching out and taking a child's hand, putting a block in it, and saying, "Here is a block; want to play with me?".

Additional information on methods to increase social skills and interaction with children with severe disabilities can be found in the book *Social Competence of Young Children With Disabilities*, by S.L. Odom, S.R.McConnell, and M.A. McEvoy, Paul H. Brookes Publishing Company. Your packet of information in *Appendix M*, beginning with "Social Development," illustrates some of the major principles and strategies for promoting peer interaction.

D. Planning For Future Community Settings

Ways Curriculum Design Influences Children's Participation in Future Settings

A child care curriculum designed around activity centers supports child-directed learning opportunities. As children move through their daily activities in these settings, they begin to develop the capacity to make independent decisions, self-regulate their activity and behaviors, and negotiate change. While these skills may seem like "abstract outcomes" of accepted early childhood curriculum, they are the skills basic to participation in future community settings. When children enter public schools they are expected to demonstrate these behaviors. Children with "problem behaviors" often have not had the opportunity to learn these important social skills.

In segregated special education programs or highly teacher-directed child care programs, children are generally not offered these opportunities. Often, these settings lack curriculum diversity, limit opportunities for independent decision making, and lack "natural consequences". Because children with disabilities often require more practice to learn a variety of functional skills, it makes sense that limiting their experience to segregated or highly structured programs, that do not provide opportunities for developing independence, may inhibit, rather than expand opportunities for future independence. This is why there has been a policy shift, in support of integrated early child care programs.

Integration, however, takes careful planning. The skills children learn in early intervention programs are also critical for their full participation in community life. For some children, highly structured intervention or instruction and the careful monitoring of learning and development is necessary, in order for children to develop critical functional skills. Therefore, the goal of integrated programs is combining the best of both types of programs, within an integrated program plan. Some children may receive the most benefit from being enrolled in a fully integrated program. Other children may receive the most benefit from dual enrollment; spending part of their time in specialized early intervention programs and part in regular preschool programs. Other children may need to spend time in a specialized early intervention program first, and then move into a dual enrollment or fully integrated arrangement. There is no "one best solution."

Adaptive Survival Skills Needed in Current and Future Settings

Integrated child care centers play an important role in helping children with disabilities to learn effective skills for independent living, and full inclusion in community settings. One of the many benefits of integrated child care settings for children with disabilities, is that these settings present opportunities to learn the rules and skills of childhood within a regular community setting. Some children will need more direct help in developing these skills. Child care providers have the opportunity to systematically increase children's adaptive skills, which will help children make the transitions into new educational and social settings. Following are some suggestions for helping children develop the survival skills needed in current and future settings:

1. Identifying targets for assessment - To guide curriculum decisions for young children with disabilities, Baily and Wolery (1984) advise teachers to consider the concepts of *critical function* and *next most probable placement*. Critical function refers to the concept that specific skills measured by items on assessment instruments are "indicators of more general functions." For example, perception of object permanence or spatial relationships would be considered critical functions. A test item which requires a child to look at a picture of three objects and pick the two that go together, would present obvious difficulty to a child who is blind. When an early childhood educator understands that this test item is measuring the functional skill or concept of "classification", a variety of alternate activities using the senses of touch, hearing, taste, or smell rather than vision can be used both to measure and to teach this critical function.

   The authors suggest that when teaching focuses on functional skill development, rather than specific skills (e.g. teaching items included on assessment instruments)the skills developed are more likely to be generalized. This theory applies to curriculum development for all children, regardless of ability level.

   The concept of next most probable placement refers to "the identification of skills important for success in the child's next educational environment". The authors explain: "Since a major goal of early intervention is to facilitate movement to less restrictive environments, the skills required for success in these programs should be identified and targeted (1984:35.)" The authors cite the following suggestions by Vincent, et al (1980) as possible strategies for identifying functional skills required in future environments:

(a) Conduct a brief "tryout" in the next placement setting. This could involve letting the child spend a short period of time over several days in his or her future kindergarten or preschool program. Such a strategy can help pinpoint specific problem areas and provide guidance for determining supplemental instructional targets.

(b) Follow children who have already moved to the next placement setting. This would involve a discussion with teachers to find out the skills these students needed to insure a successful transition.

(c) Ask the teachers in the next placement setting to generate a list of survival skills, This list should include social skills (such as initiating interactions with peers or making choices during free play) that are not usually tested in the assessment process.

(d) Gather objective information on survival skills actually used in the next placement setting. Observational analysis of a typical day may indicate other skills not generated by the teacher or may help rank skills in terms of frequency needed.

2. Transition Planning: Guiding the Process of Change - Transition planning can be defined as: " A carefully planned, outcome-oriented process, initiated by the primary service provider, who establishes and implements a written multiagency service plan for each child moving to a new program "(McNulty, 1989:159). Transition planning in early childhood programs involves planning ways to smooth the transitions between home and school, early intervention and child care programs, or between preschool and public school programs. Planning for transition involves anticipating and planning for the process of change. Whatever the reason for transition planning, the essential component is *establishing effective coordination between the sending and receiving agents*. Developing an effective transition plan between early childhood programs should involve program administrators and staff from each of the agencies or programs involved, as well as parents, and children. Strategies identified above, related to preparing for the next most probable placement, should be integrated within the transition plan. The process of transition planning will include the team planning skills, discussed in Unit IV.

REFERENCE

Allen, K.E., & Marotz, L. (1989). Developmental profiles. Delmar Publishers.

Anderson, P.P. & Fenichel, E.S. (1989). Serving culturally diverse families of infants and toddlers with disabilities. Washington, DC: National Center for Clinical; Infant Programs.

Bailey, D.B., & Wolery, M. (1984). Determining instructional targets. In, Teaching infants and preschoolers with handicaps. (25-48). Columbus: Merrill Publishing Company.

Berger, E.H. (1987). Parent education and leadership training. In, Parents as partners in education. (pp. 152). Columbus: Merrill Publishing Company.

Blackman, J.A. (1983). Medical aspects of children with disabilities. Iowa City: University of Iowa, Department of Pediatrics, Division of Developmental Disabilities.

Bricker, D.D., (1978). A rationale for the integration of handicapped and nonhandicapped preschool children. In, M. Guralnick (Ed.), Early intervention and the integration of handicapped and non-handicapped children. Baltimore: University Park Press.

Cook, R.E., Tessier, A., & Ambruster, V.B. (1987). Adapting childhood curricula for children with special needs. Columbus: Merrill Publishing Company.

Davis, W.E. (1986). Resource guide to special education, terms, laws, assessment. Boston: Allyn Bacon Inc.

Donnellan, A.M., Mirenda, P.L., Mesaros, R.A., & Fassbender, L.L. (1984). Analyzing the communicative functions of aberrant behavior. In, Journal of the American Association of Persons with Severe Handicaps (JASH), 9, 3, 201-212.

Foley, G. (1981). The Grief Reaction. Paper presented: Breaking the Barriers Workshop. Family Centers Resource Project, Reading,. PA.

Froschl, M., Colan, L., Rubin, E., & Spring, B. (1984). An early childhood curriculum about disability: Including all of us. Washington, DC: US Dept., of Education, Women's Educational Equity Program.

Golin, A.K. & Ducanis, A.J. (1981). The Interdisciplinary Team. Rockville: Aspen Systems Corporation.

Hawaii (1987).Hawaii Early Learning Profile (HELP). Palo Alto: VORT Corporation

Healy, A. (1983). *The needs of children with disabilities*. Iowa City: University of Iowa, Department of Pediatrics, Division of Developmental Disabilities.

Hofferth (1979) Day Care in the Next Decade: 1980-1990. Journal of Marriage and the Family, 41: Pp. 649-658.

Howard, A.E. (1984). The American family: myth and reality. Washington DC: NAEYC.

IHDI (1989). IFSP Training Guide. Lexington, KY: University of Kentucky.

Johnson-Martin, N. Jens, K.G., & Attermeier. (1986). The Carolina curriculum for handicapped infants and infants at risk. Baltimore: Paul H. Brookes Publishing Co.

Johnson, N.M., Attermeier, S.M., & Hacker, B. (1990). The Carolina curriculum for preschoolers with special needs. Baltimore: Paul H. Brookes Publishing Co.

Lynch, E.W., & Hanson, M.J. (1992). Developing Cross-Cultural Competence: A guide for working with young children and their families. Baltimore: Paul H. Brookes Publishing Co.

McNulty, B.A. (1989). *Leadership and policy strategies for interagency planning*. In, Gallagher, J.J., Trohanis, P.L., & Clifford, R.M. (eds.) Policy Implementation & PL 99-457. Baltimore: Paul H. Brookes Publishing.

Middendorf, K.L. (1988). A historical perspective of attitudes and the service system for persons with developmental disabilities. Lexington: University of Kentucky, Interdisciplinary Human Development Institute.

Middendorf, K.L. (1987). An introduction to mental retardation and other developmental disabilities. Lexington: University of Kentucky, Interdisciplinary Human Development Institute.

Miezio, P.M. (1983). Parenting children with disabilities. New York: Marcel Dekker, Inc.

Odom, S.L., McConnell, S.R., & McEvoy, M.A. (1992). Social Competence of young children with disabilities: Issues, strategies and intervention. Baltimore: Paul H. Brookes Publishing Co.

Odom, S.L. & McEvoy, M.A. (1990). Integration of young children with handicaps and normally developing children. In, Odom, S.L. & Karnes, M.B., Early intervention for infants and children with handicaps. Baltimore: Paul H. Brookes Publishing Co.

Odom, S.L., Kohler, F.W., & Strain, P.S. (1987). Teaching strategies for promoting social interaction skills. Pittsburgh: University of Pittsburgh, Western Psychiatric Institute and Clinic, Early Childhood Intervention Program.

Paasche, C.L., Gorrill, L., & Strom, B. (1990). Children with special needs in early childhood settings. Menlo Park: Addison-Wesley Publishing Co.

Pappas & Nicholson (1985). Communication Skills Handouts. Bloomington: Institute for the Study of Developmental Disabilities, Indiana University.

Powell, D.R. (1989). Families and Early childhood programs. Washington DC: NAEYC.

Preschool Integration Network. (1990). Handouts distributed at 1990 Partnerships in Progress Conference, Washington, DC.

Schiamburg, L.B. (1988). Child and adolescent development. New York: Macmillan Publishing Company.

Souweine, J., Crimmins, S., & Mazel, C. (1990). *Mainstreaming: Ideas for teaching young children*. Washington, DC: National Association for the Education of Young Children.

Stevens, K. (1988). *Basic Principles of Behavior*. Lexington: University of Kentucky, Interdisciplinary Human Development Institute.

Turnbull, A.P. (1988). A Life Span Perspective. In, *Family Resource Coalition Report, 2*. Chicago: Family Resource Coalition.

Wallis (1987) The Child Care Dilemma. *Time*, pp. 54-60.

Appendix A - F

Appendix A: Social Attitudes

Appendix B: Cultural Trends

Appendix C: Overview of PL 99-457

Appendix D: Glossary of Specialized Terms

Appendix E: Functional Disability Categories

Appendix F: Local Service Agencies

Appendix A

Social Attitudes

PERCEPTIONS AND CONSEQUENCES
OF SOCIAL ATTITUDES
ABOUT PEOPLE WITH DEVELOPMENTAL DISABILITIES

LABELS	PERCEPTIONS	CURRENT VESTIGES	
A. THE PERSON AS A	- that the person is not fully human	- abuse-proof surroundings; tin plates and cups; locks and fences	- labels (calling people by their disability)
	- seen as a vegetable or animal like	- drains in floors and mass showering for clean-ups	- exclusion from services based on severity of disability
	- dirty, smelly, likely to soil themselves	- no rights to privacy, property, communication, individuality	- lack of input into decisions, ability to make choices
	- not deserving of rights or able to benefit from services	- no choices, precontrolled water temperatures, lights, rigid schedules	- lack of rights to privacy, property, communication and individuality
B. The Person As a Menace	- Similar to the perception as a sub-human organism but incorporates fear	- segregating people in far away places (institutions, rural locations, etc.)	- inappropriate institutional placement
		- fences, barred or reinforced windows, locked doors	- inappropriate psychiatric diagnosis
		- punishing treatment; aversive therapies, drugs for behavior control	- exclusion from services
		- limited human interaction	- neighbors protesting location of group homes

LABELS	PERCEPTIONS	CURRENT VISTIGES	
C. The Person As An Object of Pity	- seen as suffering unaware of their "condition", to be pitied; not being at fault for their situation or for their actions	- cold charity (just the basics, no frills)	- fund raising campaigns that encourage pity or guilt as a reason for giving
		- services provided out of moralistic duty	- lack of basic services as a right instead of a privilege
		- parents often blamed	
		- dependency encouraged, "do for them" instead of having expectations for development	- low expectations for growth and development
			- condescending approach to parents
D. The Person As A Holy Innocent	- children of God	- opposite of dehumanization; puts the person above the human level	- names of programs (Example: Home of the Innocents in Louisville)
	- saintly		
	- holy and innocent	- limits expectations	- poems and literature aimed at parents
	- having a special purpose; a blessing in disguise	- creates difficult role for parents	- some church-run programs
E. The Person As Sick	- viewed as sick	- "medical model" for service delivery	- clients referred to as patients
	- having an incurable disease	- education, work, recreation thought of as therapies	- service records called medical records

LABELS	PERCEPTIONS	CURRENT VISTIGES	
	- in need of medical care	- physicians diagnose patients who receive treatment in hospitals and clinics	- utilization of health care funds to provide residential, vocational, recreational services, i.e. Title XIX
		- excused from normal social responsibilities	
F. The Person As An Object of Ridicule	- someone to be made fun of	- lack of respect and human dignity etc.	- reference to disabilities in comedy routines, cartoons,
	not worthy of respect	- exploitation; historically the court jester and carnival side show attractions were people with disabilities	- continued joking references everyday speech, print media, etc.
G. The Person As An Eternal Child	- younger than their chronological age; having the mind of a two year old	- low expectations	- age appropriate activities, dress possessions
	- child-like	- few demands made on the person	- policies which prohibit sexual expression
	- incapable of learning adult skills and behavior	- opportunities for growth denied	- lack of work opportunities
	- lacking sexuality	- age inappropriate services, dress, activities, possessions	- over-protection by staff and parents

LABELS	PERCEPTIONS	CURRENT VISTIGES	
*The Person As A Developing Citizen	- having individual value and rights as a human being	- invidualized services based on individual need	- legislation which upholds rights
	- having potential for growth regardless of severity of disability	- friendships and relationships	- increased advocacy for services which reflect these perceptions
		- skilled staff providing quality training	- increased concern for
	- deserving of opportunites for normal experiences and opportunities to participate in the mainstream of society	- integrated community based residential, work work and recreation opportunities	

Appendix B

Cultural Trends

HIGHLIGHTS IN WESTERN CULTURE
FAMILY - DD SERVICES - EARLY CHILDHOOD EDUCATION

	FAMILY STRUCTURE	SERVICES FOR PEOPLE WITH DISABILITIES	EARLY CHILDHOOD EDUCATION
PRE 1800's IGNORANCE & NEGLECT	- Slightly over half of all children live to be adults. - Families are formed as political and social units rather than for intimacy and childrearing functions. - Infanticide, physical abuse, abandonment, and sexual exploitation of children are common and accepted. - Harsh child-labor practices prevalent; children are somtimes maimed to become better beggars. - The "shopkeeping" families initiate domestic and nuturing roles for "mothers".	- Little consideration is given to people with disabilities - As many as 80% of the people in prisons and poor houses during the 18th century have some type of disability.	- 1600's John Locke promotes the concept that the mind of an infant is a "blank slate", challenging the myth that children are born full of evil. - 1700's Jean Jacques Rosseau argues that children's education should begin at birth, and be grounded in compassion rather than harsh discipline.

	FAMILY STRUCTURE	SERVICES FOR PEOPLE WITH DISABILITIES	EARLY CHILDHOOD EDUCATION
1800 - 1900 RECOGNITION & SHELTER	- Childhood is beginning to be valued as a unique period of human development. - Women challenge segregated male recreational clubs and pressure men to spend more time at home. - Role of "father" emerges. - Nuclear family is rapidly being established as accepted family form.	- The first empathic attempts to understand and respond to the needs of people with disabilities occurs. - 1800 - Jean Marc Itard - France - "Wild Boy of Aveyron". - 1817 - Thomas Gallaudet - Connecticut - First School For the Deaf. - 1832 - Samuel Howe - Boston - First School for the Blind, later expands to serve childwith mental retardation. - Mid- 1800's - Edouard Seguin - France publishes textbook on mental retardation, works with children with mental retardation, later moves to America establishing transitional residential educational institutions for children with mental retardation and establishes the American Association on Mental Deficiency.	- By 1800 Johann Pestalozzi establishes a resiential school for children abandoned as a consequence of the French Revolution; his writings emphasize that early education should be based on children's natural development, and that the home should serve as a model for learning, with "mothers" being the best teachers. - By 1830, Friedrich Froebel establishes the first kindergartens in Germany. - Mid-1800's private kindergartens are being established in the United States. - 1873 - The first public kindergarten is established in the United States.

	FAMILY STRUCTURE	SERVICES FOR PEOPLE WITH DISABILITIES	EARLY CHILDHOOD EDUCATION
		- 1850 - National Education Association establishes a division concerning the needs of the physically and mentally handicapped, later becomes the Department of Special Education.	
1900-2000 SOCIAL REFORMATION	Early twentieth century: - "Women's place is in the home." - 1950's Revolution in family roles and structure begins, as women seek higher education and professional employment. - 1950's - 1960's The Civil Rights movement initiates broad social reform to human equity issues. - The "nuclear family" is replaced by "diversity of family structure" as the accepted social norm. - 1990's: one in five children will spend some period of their childhood in a single-parent home. - 1990's - Fifty percent of mothers return to work before their child's first birthday, eighty-ninety percent of mothers will be in the workforce prior to their child's fith birthday.	- 1900 - 1960'S Residential institutions increasingly become long-term custodial care facilities, as people with severe disabilities do not return to home communities. - 1940's - American War Veterans return home with physical and emotional disabilities, stirring new compassion for people with disabilities. - 1950's Civil Rights Movement is a catalyst for a series of class action suits against large custodial care institutions, accused of "warehousing" people with disabilities. - 1960 - present Federal legislation passes supporting human rights, free appropriate education, due process guarantees, and community based services.	- 1904 France - Alfred Binet designs a test to identify children in need of special instruction - Early 1900's: Italy - Maria Montessori, a physician works with children with mental retardation, establishes a nursery school for poor children emphasizing and encouraging self-help skills, reading, writing, and arithmetic. - Jean Piaget uses an observational case-study approach to study the development of children's thinking, and identifies stages of cognitive development. - John Watson introduces theory of behavior emphasizing the contribution of environmental

Appendix C

Overview of PL 99-457

Summary: Kentucky Enabling Legislation For PL 99-457

P.L. 99-457: 1986 Amendments to The Education for All Handicapped Children Act:

In September 1986, Congress renewed and strengthened commitment to the guarantee of free, appropriate public education for the nation's children with disabilities. Through passage of P.L. 99-457, provisions of P.L. 94-142, The Education for the Handicapped Act (EHA), were extended to children with disabilities ages 3-5 years of age, and a state incentive program was added, to encourage states to develop and expand early intervention programs for infants and toddlers.

New or expanded provisions of P.L.99-457 include:

-The Preschool Grant Program for children aged 3-5(Title II: Sec.619)

This new program is mandatory for states participating under PL 94-142, and requires that State Education Agencies serve all 3,4,and5-year-old children with disabilities by the 1990-91 school year.

Requirements included in P.L.94-142, which now, also, apply to children ages 3 - 5 years of age, include:

- Non-discriminatory testing;
- Placement in the Least Restrictive Environment (LRE);
- Development of the Individualized Education Plan (IEP);
- Provision of support services;
- Parents rights; and
- Procedures for due process.

In addition, the legislation strengthens the role of parents, by providing that instruction and training for parents be included in the preschoolers IEP, whenever appropriate, to enable parents to assist more effectively in their child's progress.

Another significant modification relates to eligibility. States are no longer required to use diagnostic labels, or "categorical documentation" when counting the number of children served. The revised provisions allow states to provide services to 3,4, and 5 year old children without labeling, by using the term developmental delay. State regulations must, however, define what criteria will be used to determine qualification for developmental delay and eligibility for services.

States are also allowed to serve preschoolers in ways that vary from the typical school day model. By encouraging local education agencies to contract with existing preschool programs, a variety of service models may be made available, including home-based, center-based, shared enrollment, and other model variations.

- Infant Toddler Program (Title I: Part H, Sec. 671)

The second program established by PL 99-457 continues Congressional commitment to early intervention and family involvement by providing new funding for services to children with identified disability, or who are "at risk" for disability, who are ages birth - three. Unlike the mandatory preschool program, this provision of the law is voluntary for states.

The Part H program provides funding to states to help them develop and implement state-wide, comprehensive, *interagency,* programs of early intervention services. The state-wide program is directed to facilitate the coordination of all appropriate, existing early intervention resources including those financed by government and private sources. The law also authorizes funding to enhance the states' capacity to provide *quality* early intervention services.

This new Infant Toddler Program is directed to the needs of children experiencing delays in one or more areas of development; children who have physical or mental conditions which have a high probability of resulting in developmental delay, such as Down Syndrome or cerebral palsy; and may include children who are at risk of substantial developmental delay because of medical or environmental influences.

Funding under this program is not limited to direct services to the child, but includes authorization for services to parents to facilitate their child's development. Rather than an Individualized

Education Plan (IEP), program guidelines call for Individualized Family Service Plans (IFSP), recognizing this new provision. For each eligible child, services must include:

- a multi-disciplinary evalustion and assessment, and
- a written Individualized Family Service Plan (IFSP).

Requirements for the IFSP include:

- development of the IFSP by a multidisciplinary team including the child's parents;
- a statement of the child's present level of functioning in all developmental areas;
- a statement of the family's priorities, concerns, and resources which relate to enhancing the child's development;
- a statement of goals and objectives for the child and family;
- the criteria for determining progress;
- a listing of specific services necessary to achieve the stated goals and objectives;
- designation of a case manager (service coordinator); and
- procedures for transition from the Infant-Toddler Program into the Preschool Program.

The IFSP Committee must evaluate and revise the IFSP at least once a year, and review progress at least every six months.

Funding is allocated to states based on the total number of infants, birth to three in each state compared to other states census figures, rather than the actual count of children served under the program.

In 1990, additional amendments to EHA officially changed the name of the act to the Individuals With Disabilities Education Act (IDEA), and replaced the term "handicapped children" with the term "children with disabilities" throughout the act.

(Adapted from : P.L. 99-457 The New Law, Chapel Hill Training Outreach Videotape script.)

Kentucky's Enabling Legislation for the Preschool Grant Program:

In order to comply with the federal mandate for free appropriate education to all 3-5 year olds with disabilities under the Preschool Grant Program, Kentucky passed enabling legislation during the 1990 legislative session. As originally proposed House Bill 256 would have:

> Required school districts to provide services to children with disabilities ages 3-5 beginning with the 1991-92 school year, for children whose families want those services;
>
> Provided funding through an accompanying Kentucky Department of Education budget request of $23 million to school districts to establish programs or to contract for programs with existing early childhood services such as Head Start and other special and regular early childhood services.

As enacted, HB 256 was incorporated into the omnibus Kentucky Education Reform Act (KERA) as Section 17, and requires provisions by school districts, as above, for all 3-5 year old children with disabilities, who become eligible for such services on their third birthday.

The funding authorization was not included as requested. In lieu of requested funding, the education bill authorized a total of $18 million for combined Pre-K programs during the 1990-1991 school year, and 36 million for the 1991-1992 school year. This authorization included funding for Section 17 programs, as well as Section 16 programs which provide Pre-K programs for at-risk four year olds (with eligibility based on enrollment in free lunch programs).

Kentucky's Enabling Legislation for the Part H Infant Toddler Program:

In 1987, then Governor Martha Layne Collins, designated the Kentucky Cabinet for Human Resources (CHR) as the lead agency for development of the Kentucky Infant Toddler program, as authorized by P.L. 99-457, Part H. The CHR was in a unique position to take the lead in development of the program, because the major departments of government with existing resources serving this population are located within the CHR. The Cabinet remains the lead agency, with staff from the Department of Mental Health/Mental Retardation Services and from the Department of Health Services providing the leadership support for implementation.

In the fall of 1988, then Governor Wallace Wilkenson appointed a state Interagency Coordinating Council(ICC) that conforms to the requirements of the act for providing representative interagency coordination in developing program policy. The role of the Council is to advise and assist the lead agency in the development and implementation of the comprehensive early intervention system

In 1992, Kentucky entered the fifth year of planning, under federal provisions which allow extended participation for states who are implementing comprehensive early intervention evaluation and assessment, and service coordination functions, but are still in the planning stages for developing the early intervention system in preparation for providing entitlement services. In order to continue receiving Part H funding, Kentucky will need to complete planning activities, and have the early intervention system ready to provide early intervention services to all eligible children whose families request such services, by the 1994-1995 fiscal year.

Appendix D

Glossary of Specialized Terms

I. Individualized Service Plan Process

Care coordination (case management, service coordination)	The act of providing assistance necessary to ensure the effective and efficient organization of and access to services and resources that are appropriate to meet child and family needs. Care coordination includes a process of negotiating, facilitating, and advocating for the delivery of services that are included in the service plan.
Case management (service coordination)	A variety of case management models and programs have been developed that offer a continuum of coordinated services, reflecting differing levels of service intensity. For the purposes of this document, the terms case management, service coordination, and care coordination are used synonymously.
Community-based Services	Delivered at a local level or as close to the child's home as possible; the major responsibility for planning, designing, and implementing the services rests within the community as defined by the family.
Comprehensive	The combination of a broad range of health, educational, social, and related services identified as important in habilitation, related to an individual's level and type of disability.
Continuous Care	Maintained without interruption despite changes in the child's service delivery site, care-givers, or method of payment.
Coordinated Care	Planned and implemented to form a cohesive therapeutic program; should involve family - centered, interagency, and interdisciplinary collaboration.
Cross-categorical	A program designed to serve children who have different types of categorical disabilities, within the same program.
Developmental Services	Services designed to facilitate development, planned in relation to an individual's functional level and chronological age. Functional level includes physical, cognitive, psychosocial, and communications development.
Disabling condition	Any condition that interferes significantly with normal functioning and development.
Documented	All aspects of care (assessment, problem-identification, ongoing interventions, and outcomes) are periodically recorded in a system that is easily accessible to the family, service providers, and authorized monitors/evaluators of an individual's service plan.
Family-centered	Program and service provision that recognizes and respects the pivotal role of the family in the lives of children, which supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the child.

Family participation	The process by which the child and family work in collaboration with professionals in decision-making, planning, or service delivery.
Family supports	A range of programs or services that respond to priorities and needs as identified by family members. Such services may include parent networks, babysitting/day care, equipment exchanges, advocacy services, respite care, and any other assistance that facilitates family life activities and participation in the community.
Geographically-available	Care that is accessible to all children regardless of place of residence.
Individualized Services	A) Service plans that reflect the unique physical, developmental, emotional, social, educational, and cultural needs of the individual within the context of their family and community. B) Services designed and implemented to address an individual's particular needs.
Integrated Services.	A) Multiple therapeutic services which are planned and provided in an integrated (coordinated) fashion. B) .A term referring to the inclusion of children with disabilities in regular educational programs C) Service programs that include a system for communication and advocacy in order to ensure that the individual and his/her family participate fully in all aspects of society.
Interdisciplinary Process	A process of communication and interaction among persons who bring a variety of diagnostic, therapeutic, and habilitative skills and knowledge to bear upon the development and implementation of a service plan; process used to develop a coordinated, comprehensive, service plan.
Multidisciplinary team (interdisciplinary team; transdisciplinary team):	Professionals with a variety of different skills and training who are addressing the multiple habilitative needs of individuals with disabilities. Multidisciplinary = working separately; Interdisciplinary = working separately, but maintaining team communication through regular interdisciplinary team meetings; Transdisciplinary = working together and sharing knowledge and skills among team members, enabling team members to develop and implement service plans in an integrated fashion.
Non-discriminatory	Services available to all individuals and their families regardless of race or ethnic identity, primary language, religion, gender, marital status, medical condition, or method of payment.
Safe	Care that is free from unnecessary risk by ensuring use of adequate facilities, staff, procedures, and equipment.

II. Health

High incidence	A disorder or disability that occurs in a relatively high number of people, in comparison with other disabling conditions.

Low incidence	A disorder or disability that occurs in a relatively small number of people, in comparison with other disabling conditions.
Acuity	Degree to which one is able to hear sounds and see visual images.
Anomaly	Abnormality.
Apnea	A temporary absence of breathing.
Body awareness	Awareness of one's own body and its position in time and space. (image)
High risk signs	Physical or behavioral characteristics which are known to indicate a higher than average likelihood of a child having a disability.
Hyperactivity	Exceedingly active behavior not typical of most children.
Hypoactivity	Opposite of hyperactivity; lethargy.
Pediatrician	A physician whose speciality is working with and treating infants and children.
Prosthesis	Artificial device used to replace a missing body part.

III. Education

Individuals With Disabilities Education Act (IDEA)	The current title of the federal law which guarantees people with disabilities a free and appropriate education. P.L. 94-142, Education of the Handicapped Act, which was enacted in 1975, was the first enactment of the law. P.L. 99-457, 1986 amendments expanded the act to include children 3-4 years of age within statutory requirements of the law, and added the Part H, Infant Toddler Program ,which provides incentives to states to develop comprehensive early intervention programs for infants and toddlers. Amendments in 1990 officially changed the name of the act to the Individuals With Disabilities Education Act, and replaced the term"handicap" with "disability" through the act.

Individual education plan (IEP)	Under IDEA , every child of school-age, identified as disabled, must have a written educational plan (IEP) developed and implemented. The IEP must be developed following a multidisciplinary assessment. The program (plan) for each child must be developed by a multidisciplinary team, and must include (1) a statement of the child's present levels of educational performance, (2) a statement of annual goals including short-term instructional objectives, (3) a statement of the specific special education and related services to be provided to the child and the extent to which the child will be able to participate in regular educational programs, (4) the projected dates for initiation of services and the anticipated duration of services and (5) appropriate objective criteria, evaluation procedures, and schedules for determining on at least an annual basis whether the short-term instructional objectives are being achieved. The IEP is not a legally binding document but is intended to represent a parental-school cooperative effort to define specifically the child's educational objectives and to determine how they are to be obtained and measured.
Individual Family Service Plan (IFSP)	Under PL 99-457, Part H, Infant Toddler Program, an individualized plan of providing early intervention services to children ages birth to two with disabilities and their family, similar to an IEP for school age children. The law requires multidisciplinary evaluation and assessment to be carried out in coordination with IFSP development, and for parent priorities, needs, and resources to be considered along with the needs of the child in plan development and service implementation.
Free Appropriate Public Education (FAPE)	Designed by Public Law 94-142 to mean special education and related services provided at public expense. Such services are to be described in the individualized educational plan, to be appropriate to the child's individual needs, and to meet requirements of the state education agency.
Least restrictive environment (LRE)	This is a concept inherent in Public Law 94-142 that requires children with disabilities to be educated with peers in regular educational settings to the maximum extent appropriate.
Anecdotal record	A factual account of a child's behavior.
Behavior management	A) Systematic, consistent efforts to change an individual's behavior. B) Carefully planned consequences for specific behaviors are designed to help a learner develop new and appropriate responses to situations and experiences.
Behavioral objective	A statement describing a students learning objective, that specifies the criteria for an observable behavior, which will demonstrate that the learning objective has been achieved.
Emerging skills	Skills that an individual is in the process of learning. As children learn, they may use a new skill some, but not all of the time. A skill observed at least some of the time is said to be emerging.

En route behaviors	Tasks to be mastered, or behaviors to be demonstrated, as the child moves from one level of functioning (entry behavior) to a designated goal or objective (terminal behavior).
Modality	The sensory pathways through which an individual receives information and thereby learns. Some individuals are thought to learn more quickly through one modality than another; for example, some process auditory information more efficiently than visual information and would thus be classified as auditory learners.
Modeling	Providing a demonstration of a behavior.
Multisensory learning	A technique to facilitate learning that employs a combination of sensory modalities at the same time.
Nonverbal ability	Having skill to perform a task that does not involve using words.
Norm-referenced tests	Tests that report a particular child's performance in relation to other children of the same chronological age. Such tests are standardized according to the population of individuals involved in test development. Tests to be used with children having disabilities will need to have included children with similar disabilities in the population for which the test was standardized, in order to be reliable and valid measures of children's ability.
Prompting	Using cues and partial cues to build desired behavior. Verbal prompting often involves saying a single sound or word to help a child remember what to say or do. Physical prompting that involves physical assistance or touch can be helpful to initiate a motor or self-help skill. Prompts should be reduced gradually (faded) until they can be eliminated.
Reinforcer	An event or consequence occurring following a behavior, that increases the likelihood of a behavior being repeated. May be concrete or social.
Reverse chaining	To begin teaching with the last step of a task and working backwards. Particularly useful with self-help skills.
Risk analysis (Task analysis)	Breaking down a difficult task into small steps that lead to doing a complex task. En route behaviors are subskills which are mastered on the way to mastering the complex task, or terminal objective.
Self-fulfilling prophecy	The tendency for individuals to behave in the ways they think other people believe they should be behaving.
Seriation	Ordering according to relative differences.
Shaping	A technique of behavior modification in which behaviors that are successive approximations of the target behavior are reinforced until target behavior is acquired.
Successive approximation	The process of gradually increasing expectations for a child to display behaviors that are more like the desired target behavior; used in shaping behaviors not previously a part of the child's behavior pattern.

Terminal objective	The behavioral objective that a particular teacher has chosen as the highest level of skill he or she intends children to achieve.

IV. Technical Terms

A. Hearing

Audiologist	A trained professional who measures hearing acuity, diagnoses hearing impairments, and assists in planning for remediation, including hearing aids and educational adaptations.
Ontologist	A physician trained to treat problems of the ear.
Audiometer	An instrument used to measure auditory acuity. Measurements are generally taken in decibels of loss at various frequencies within the range of normal hearing.
Audiometric zero discrimination	Refers to the lowest level of sound barely perceivable by the typical hearing individual.
Auditory	The ability to distinguish one sound from another.
Auditory memory	The ability to retain and recall what has been heard.
Residual hearing	Auditory acuity of an individual after an impairment without amplification.
Marked hearing loss	Conversation must be loud in order to be understood and the individual is likely to have difficulty with speech, language, and vocabulary.
Mild hearing loss	The individual can generally understand conversational speech at a distance of 3-5 feet if facing speaker, but may miss as much as 50% if voices are faint.

B. Occupational Therapy

Occupational therapist (OT)	A trained professional who works with individuals or groups by providing specific activities designed to improve their physical, social, psychological, and/or intellectual development. Occupational therapists are commonly employed in rehabilitation programs for individuals with disabilities and frequently focus on the development of fine motor skills and perceptual abilities. [See occupational therapy.]

Occupational therapy (OT)	The use of creative and manual activities designed to help people with various types of disability to achieve greater mastery of their bodies and increased ability to cope socially in their environment. Both individual and group activities usually are provided and are geared to the age, physical condition, and interest of the individual. Occupational therapy is a valuable treatment technique, especially useful in the rehabilitation of individuals having a physical disability.
Physiotherapy	Treatment of disorders of movement.
Pincer grasp	Coordination of index finger and thumb.

C. Physical Therapy

Physical therapist (PT)	A professional trained to work in the general area of motor performance
Physical therapy (PT)	Services provided by a trained physical therapist in the general area of motor performance. Services may focus on correction, development, and/or prevention of motor related problems.
Abduction	Movement of a limb outward (away) from the body.
Adduction	Movement of a limb inward (toward) the body.
Asymmetrical	Unequal; lack of similarity in form between two sides of the body.
Ataxic	Unbalanced and jerky.
Athetoid	Moving uncontrollably and continuously.
Contracture	Permanently tight muscles and joints.
Coordination	Harmonious functioning of muscles or groups of muscles in movement.
Diplegia	Condition of cerebral palsy with major involvement of the arms.
Dystrophy	Weakness and degeneration of muscle.
Eversion	Turning out.
Extension	Straightening of trunk and limbs of body.
Flexion	Bending of elbows, hips, knees, etc.
Hypotonicity	Condition in which muscles are limp and do not exhibit resistance to stretching.
Hypertonicity	Condition in which muscles are stretched and constantly excited.
Nonlocomotor	Lack of movement from one place to another.

Paraplegia	Paralysis of both legs.
Prone	Lying on belly.
Quadriplegia	Condition of cerebral palsy with major involvement of arms and legs.
Rigidity	A type of cerebral palsy characterized by widespread continuous muscle tension. Muscles of the body become very stiff.
Righting	Ability to put in or restore the head and body to a proper position when in an abnormal or uncomfortable position.
Scissor pattern	Body movement in which one leg crosses over the other.
Spasm	Sudden tightening of the muscles.
Spasticity	Muscular incoordination resulting from sudden, involuntary contractions of the muscles; a type of cerebral palsy.
Supine	Lying on back.
Tone	Firmness of muscles.

D. Speech/Language

Speech-language pathologist (SLP)	A professional who works with individuals having problems in the areas of speech and/or language. A speech-language pathologist commonly works with both the assessment and programing/treatment aspects of articulation, dysfluency, and voice disorders as well as with language development and language disorders. Certification as a SLP requires completion of a master's degree, including a supervised internship, in a program approved by the American Speech-Language-Hearing Association (ASHA).
Speech pathology	The field devoted to the diagnosis and treatment of speech disorders, and/or lack of normal speech development.
Echolalia	A habit of repeating (without meaning), or "echoing" what is said by others.
Encoding	The act of expressing oneself in words or gestures.
Parallel talk	Process of parents, or other adults in the presence of young children talking about what the children are doing as it is happening. This practice appears to help young children learn language.
Perseveration	Continuous repetition of the same action characterized by the inability to shift readily from one activity to another.
Speech Audiometer	An instrument detecting an individual's detection and understanding of speech rather than just using pure tones to detect a hearing loss.

Speech audiometry	Procedures employed to measure an individual's detection and understanding of speech. Also includes the assessment of a person's speech reception threshold, the decibel level at which a person is able to understand speech.
Stuttering	A speech impairment evidenced by hesitations, repetitions, or spasms of breathing.
Receptive language	The ability to understand the intent and meaning of someone's effort to communicate.

E. Vision

Ophthalmologist	A physician trained in the diagnosis and treatment of diseases of the eyes.
Optometrist	A vision specialist trained in the diagnosis and treatment of diseases of the eyes.
Optician	A vision specialist trained to measure refraction and prescribe glasses but not licensed to treat eye diseases.
Vision Specialist	A specialist trained to teach specified learning techniques to individuals with visual impairment.
Figure-ground discrimination	The ability to attend to one aspect of a visual or auditory field while ignoring other aspects of the environment in the background.
Ocular pursuit	Following an object with the eye.

Appendix E

Functional Disability Categories

COGNITIVE DISABILITIES

DEFINITIONS

Cognitive Disability refers to intellectual capacity or information processing that is impaired as the result of impaired learning ability. Two distinct categories of cognitive disability are **mental retardation and learning disabilities.**

Mental Retardation is defined as a significant subaverage intellectual functioning, existing concurrently with deficits in adaptive behavior. There are over 300 known causes of mental retardation, including various genetic, prenatal, natal, post-natal, and environmental factors; these known factors account for only 25% of the people who have mental retardation.

Learning disability occurs in individuals of normal intelligence who experience a disorder in understanding or processing language including difficulties in listening, talking, thinking, reading, or math. The causes of learning disabilities are varied and generally unknown in specific cases. However, learning disabilities generally are considered due to neurological disorders involving the central nervous system.

CHARACTERISTICS

Except on the presence of severe mental retardation, cognitive disabilities may be difficult to detect in children birth - five years of age. This is because difficulties in learning academic skills are generally the indicators for referrals and further assessment. Because of the difficulty in accurate diagnosis in young children, if a descriptor is needed to identify children, the term developmental disabilities is the preferred "label".

The severity of a child's cognitive disability will affect the rate or capacity for learning. Severe or profound mental retardation accounts for only 5% of people with mental retardation and can be identified at birth or soon after. Children with severe mental retardation will experience extreme limitations in intellectual capacity and adaptive functioning. Children with moderate mental retardation develop at about one-half the rate of children without disabilities of the same age. Language and speech development may be difficult for children with moderate mental retardation, with young children frequently being able to understand more that they can say. Approximately 75 % of people with mental retardation experience mild mental retardation. Children with mild mental retardation develop at about two-thirds to three-quarters the typical rate of development. Each child will be somewhat different developmentally; some children will experience no delay in gross-motor skills while not using speech or language, while others may speak in short phrases but not be toilet trained. Some of the general characteristics of children with mental retardation include the following: short attention spans, difficulty with transitions, difficulty understanding long verbal directions, or responding immediately to questions or directions.

Children with suspected learning disabilities generally are similar in development to their peers, except for some interference in information processing functions. For example, these children may find it difficult to attend or concentrate, experience difficulties in visual or auditory processing of information, have poor memories, have difficulty in making generalizations, and/or exhibit excessive motion.

COMMON TERMS

developmental delay
learning impairment
brain damage
mental retardation
cognitive delay
slow learning
mental deficiency
neurological impairment
learning disability
cognitive impairment

HELPFUL QUESTION

Because cognitive disabilities are not necessarily "evident" to the general observer, child care providers may be the first to identify a suspected cognitive delay. If a delay is suspected, child care providers will want to ask parents if behaviors observed in the child care setting occur at home. A record of both child care setting and at-home behaviors should be recorded, with appropriate interventions provided. After the record has been shared with parents, the child care provider may suggest that the parents request a full assessment of their child's development. Professionals who may be able to assist parents and child care providers to identify delays and appropriate interventions include early childhood special education specialists, occupational therapists, pediatricians, and child psychologists.

For a child with an identified cognitive disability, child care providers may want to:

Ask parents about behavioral strategies used at home to encourage optimal development.

Ask special education consultants about appropriate methods to record behavior and to provide direct instruction.

Ask speech and language specialists for assistance in providing appropriate speech/language assessment and interventions, if needed.

Ask occupational therapists to provide assistance in developing interventions to encourage functional development skills required for daily living, if needed.

HELPFUL STRATEGIES

Help the child to be as independent as possible by --

Avoiding treating the child like the "baby" of the group.

Including each child as fully as possible in all activities -- if the child is four and his/her abilities are more like the three-year-olds, adjust activities to provide for multiple developmental levels, so that there is room for the child to achieve success within their age-appropriate peer group.

Making the child responsible for a part of the classroom routine, making sure that the task is something they can do alone or with very little assistance.

Helping parents, other adults and the child's peers to understand the child in not "dumb" or stubborn, but has the capability to learn and achieve personal successes just like all other people do.

Provide the child with opportunities for success by --

Preparing the child in advance for classroom transitions and providing consistent classroom routines and structure.

Being patient -- a child with a cognitive disability may need a longer time to understand and respond to directions, and may not generalize easily. It may be necessary to show a child how to do something many times.

Giving directions one at a time until a child can handle more than one, showing the child how to do something rather than just telling, and providing gentle physical assistance/guidance to assist the child carry out the direction until the child learns to carry out the direction unassisted.

Analyzing tasks, breaking them down into small steps as are needed for success, and presenting instructions using short sentences and simple vocabulary.

Presenting curriculum content, in short segments, using a multisensory approach (e.g., audio, visual, manipulative). Use concrete examples to introduce new concepts, and provide for repeated practice of skills in multiple situations and settings.

Helping to focus learning by avoiding visually or auditorily "cluttered" learning areas and/or instructional materials.

Assist other children in understanding and knowing ways of effectively interacting with the child by --

Paying attention to other children's attitudes and interactions with the child; helping children to understand that the child is not "dumb" or stubborn, but may need the other children's help in learning how to do certain activities.

Encourage peer modeling and tutoring activities; being sure to acknowledge each of the children's accomplishments, both as individuals and as a "team".

HEALTH IMPAIRMENTS

DEFINITION

A child with a chronic childhood illness may have a Health Impairment if the illness interferes significantly with functional development. The term health impairment covers a broad range of chronic childhood illness including AIDS, allergies, anemia, cancer, cystic fibrosis, juvenile diabetes, epilepsy, heart defects, hemophilia, muscular dystrophy and sickle-cell disease. While 4% of the total population of children and young adults may be expected to be experiencing an acute illness at any given time, only .3% of this age group would have a chronic health impairment.

Characteristics

Children with health impairments will need to be under the supervised care of health care providers. Acute phases of illness may mean that the child will be absent from child-care or experience intermittent hospitalization. The child's activity level may be curtailed due to illness. Children with health impairments are more prone to common childhood illness such as colds, ear infections, and stomach aches or diarrhea. Social/Emotional issue may arise as the child copes with various phases of their illness or as a result of inhibited peer interactions.

Common Terms

acute
episodic
primary & secondary disorder
chronic
health crisis

Helpful Questions

Ask the child's parents and health care provider to help in planning the child's program. Prepare a list of typical classroom activities and ask if any activities to meet the child's needs.

Helpful Strategies

Assist the child to be as independent as possible by --

> Helping the child to understand their health problems and care needs so that they can begin to make decisions for themselves about what activities need to be avoided and/or when they may be entering an acute episode of illness and need to see their doctor.
>
> Not restricting children's activities unless there is a clear physical or emotional danger.
>
> Encouraging children to discuss or act-out their questions, concerns, or fears related to their illness. Be open and supportive of children's emotions.

Provide the child with lots of opportunities for success by --

> Scheduling classroom activities so that there are choices between strenuous and quiet activities.

Having teachers and peers stay in touch with children who are absent for long periods with cards, pictures, tape recordings and telephone calls.

Assist other children in understanding and knowing ways of interacting with the child by --

Teaching children about the health impairment (many children are afraid they can "catch" the illness. There are excellent books to help children understand illness and prepare for hospitalization.

Preparing children for possible "crisis" events through a curriculum unit dealing with emergencies including fire and earthquakes as will as medical crises. This is a good preventive measure for all children and will help a child with a health impairment not to feel "different" if a medical emergency does arise.

Hearing Impairments

Definition

A Hearing Impairment is a loss of auditory sensitivity ranging from mild to profound, which may affect one's ability to communicate with others. Deaf students include those whose hearing impairments are so severe they do not learn primarily by auditory means, even with amplification, and need specialized instruction to develop language, communication and learning skills. Children with hearing impairments sometimes acquire speech and language by auditory means, although they may experience difficulty in oral communication, language and learning skills, with or without amplification, and may need instructional modifications to make full use of educational experiences. While 3% of children/young adults may experience mild or temporary hearing disorders, only .2% of this age group are deaf/hearing impaired.

Characteristics

Early development milestones will be similar to those of the hearing child. The impact of a hearing impairment is most obvious in language development. Actual cognitive ability is hindered only to the extent that performance depends on language comprehension and use. Children with hearing impairments may exhibit inappropriate behavior due to lack of understanding or resulting socialization problems.

Helpful Questions

Ask specialists (audiologist, ontologist, speech and language pathologist) to assist in understanding the degree to which development of communication skills will be affected by the condition and how classroom activities can be adapted to meet the child's needs.

Ask parents how much hearing capacity the child does have and which teaching methods and communication systems (oral vs. total communication) to be used with children having more severe impairments.

Helpful Strategies

Help the child to be as independent as possible by teaching the child to change a hearing aid battery and/or cord. Provide the child with lots of opportunities for success by --

> Working closely with the audiological and speech and language specialists in planning programs for a child.
>
> Always gain the child's attention before giving a direction with a hearing impairment and demonstrate the direction if needed. Speak at normal speed and volume without exaggerating lip movements.

Seating the child up close for good visibility of teacher, activity, or other children. Use visual and tactile aids; model the desired behavior whenever possible.

Encouraging speech in group activities by allowing time for the child to start and finish speaking.

Using the child's name when seeking the child's attention. Teach the child to attend to your face, and do not give any directions until the child is obviously attending.

Avoiding speaking with your back to the child or with a bright light behind you. Don't inadvertently cover your mouth when speaking.

Assist other children in understanding and knowing ways of effectively interacting with the child
by --

Teaching children about hearing impairments and alternate methods/technology used to assist in communication (hearing aids, sign language, visual cues).

Helping children to practice the strategies listed above when playing/interacting with the child with a hearing impairment.

VISUAL IMPAIRMENTS

Definition

Blindness: no vision or minimal vision (light perception). Students with blindness will eventually need to learn braille or use other non-visual media.

A legally blind person has corrected visual acuity no better than 20/200 on their better eye. Such a person sees at 20 feet what those with normal vision see at 200 feet.

Low vision - limited distance vision: People with limited are able to see items close to them. They may use a combination of vision and other senses to learn, although adaptations in lighting and size of print may need to be used. A legally sighted person is one with corrected visual acuity between 20/20 and 20/70. The term partially sighted is used where there is enough usable vision for learning with the help of magnification.

Vision loss may result from common refractive errors (nearsightedness or farsightedness) or from such impairments as amblyopia (lazy eye), cataracts, cornea damage, detached retina, glaucoma, and retinitis pigmentosa.

While as many as 25% of children and young adults may require corrective lenses, only approximately .1%. of this age group have a visual disability.

The effect of visual problems on a child's development will depend on the severity, type of loss and age of onset, and overall developmental functioning of the child.

Characteristics

Many of the children enrolled in integrated child care programs will have some functional vision. Visual impairments do affect other areas of development. Delays have been noted in motor milestones that require self-initiated mobility (i.e. elevation of self by arms, raising to a sitting position, or running). Delay in use of the hands results in delay of concept development. Language differences may become more noticeable around the age of three. Many children with severe visual impairments experience difficulty with personal and possessive pronouns. In general, both cognitive and language development may be hindered by lack of stimulation.

Two important considerations to keep in mind are that children with visual impairments --

May miss normal experiences in the environment because they are unable to see the activity.

Because the child cannot see, will not be able to spontaneously imitate social behavior or respond to non-verbal cues.

Common Terms

myopia
visual impairment
blind
visual acquiety
amblyopea
depth perception

Helpful Questions

Ask parents if they have had their child's eyes examined if you observe that a child rubs their eyes, blinks, or squints excessively; has chronically red, or swollen or drooping eyelids; complains of dizziness, headaches, or nausea during activities; avoids visual activities; holds objects very close or far away; frequently tilts head; or has "wandering" or "crossed eyes".

Ask the child's parents and vision specialists to determine just what the child can see. Many children can at least see shadows, color and sometimes large pictures. Ask a mobility specialist to provide suggestions to use in classroom activities.

Helpful Strategies

Help the child to be as independent as possible by--

Orienting the child to classroom layout and materials location, giving new orientation whenever changes are made. Areas of the classroom can be identified by different tactile cues such as different floor coverings or different mobiles.

Using physical prompts when teaching new skills. Work from behind the child and gradually reduce the help given.

Being aware of lighting conditions and their effect on the child.

Teaching the child how to use auditory localization, (i.e. reaching for sound) and auditory discrimination skills; and helping the child to learn direction (up, down, upright, left) and distance instructions.

Provide the child with lots of opportunities for success by --

Trying to keep the general noise level down as a child with visual impairments relies heavily on auditory cues.

Provide clear verbal explanations and descriptions of all activities; always signal activity changes verbally.

Use multiple-sensory experiences to provide the child with a rich variety of tactile, manipulative and auditory materials and activities.

Assist other children in understanding and knowing ways of effectively interacting with the child by --

Teaching children about visual impairments and how other senses are used to gather information from the environment.

Focusing children's attention on all the things a child with a visual impairment can do and identify ways activities can be modified to use "sound" cues rather than "seeing" cues.

Encouraging children to identify themselves when they approach a child with a severe visual impairment.

BEHAVIORAL/SOCIAL/EMOTIONAL PROBLEMS

Definition

Every child is born with a "temperament" that is relatively stable--temperament is governed by human physiology. Some people are "easy-going," some people are "passive," and some people are "very active by "nature". Behavior is learned --expressed behavior patterns develop as a result of the constant interaction between an individual's temperament and environmental influences.

Behavior/Social/Emotional Disorders are characterized by **prolonged**, **frequent**, and **intense** differences from the "norm" in expressed behavior or emotion. A child may exhibit either too much, or too little of a behavior or emotion, or a behavior that is inappropriate to a setting. The causes of these problems are varied and may be due to environmental or physical factors, or both. While only approximately .8 percent of the population of children and young adults in the United States 3-21 years of age may be clinically diagnosed as having an emotionally disturbance, as many as 10 percent may be experiencing adjustment reactions due to altered or troubling environmental circumstances.

Characteristics

Some of the behaviors that may be seen in children with a behavior disorder may include the following:

Hyperactivity (Short attention span, impulsive behaviors)

Aggression (fighting, acting-out)

Self-injurious behavior (head banging, hair-pulling)

Immaturity (crying, tantrums, poor coping skills)

Withdrawal (excessive fear or anxiety, failure to initiate, extremely passive)

Autistic-like behavior (abnormal ways of relating to objects in the environment; insistence that routines remain static; slow development or lack of physical, social, language, learning skills; repetitive movements; usually high or low activity levels).

COMMON TERMS

attention deficit disorder
autism
aggressive
emotional disturbance
hyperactive
withdrawn

HELPFUL QUESTIONS

Ask parents about the child's behavior at home and in other environments; ask if there has been a change in family routines.

Seek additional information/training in non-aversive behavior management techniques.

HELPFUL STRATEGIES

The first strategy is to take an inventory of the child's behavior, using a consistent methodology to record incident, time of day, setting, and what occurs in the environment before, during, and after the incidents. While it is necessary to chart the child's inappropriate behavior, it is also important to identify positive/appropriate behavior patterns as well -- it is these patterns that need to be encouraged.

Once the pattern of behavior has been clarified, identify an intervention to remedial the behavior. The **primary goal** is to identify ways to involve the child in **positive social experiences** and to be as encouraging and positive as possible, as often as possible.

Help the child to be as independent as possible by giving lots of opportunity for success:

> Give adequate preparation for transitions by giving several reminders prior to transition. Some children will benefit from simple directions to help guide the behavior during transitions.
>
> Explain rules and routines carefully so that children know what is expected. Teaching skills of sharing, asking for help, and other "social skills" is helpful for all children and a good circle time activity. Be consistent in reminding children about routines, rules, and "good manners."
>
> Provide consistent routines. Structure in classroom organization and daily schedules gives children a secure foundation from which to explore new experiences and skills -- it is safe.
>
> Identify a child's special strength and find creative ways to maximize opportunities for the child to use the strengths in appropriate ways in a variety of settings. Provide opportunities for decision making and independent activities that help the child to become more mature.
>
> Anticipate inappropriate behavior before it occurs, and provide creative interventions to help the child avoid inappropriate behaviors: a supportive hand on the shoulder may help a child retain control; "walking the child through" difficult situations can provide guidance and modeling of appropriate behavior skills; giving a child a specific and meaningful responsibility during an identified "difficult activity/setting" can sometimes help the child focus positive energy on the task and help avoid reverting to inappropriate behavior patterns. Be patient, creative, and calm.
>
> Include curriculum options that help alleviate inappropriate or dysfunctional behavior. Dramatic play, puppets, and dress-up activities allow for expression of emotion; play

dough, clay, water tables, oversized and messy art activities allow for the release of aggressive feelings; and groups of two or three children provide an opportunity for withdrawn children to "open-up."

Focus on the positive, reinforcing the child for positive social interactions and ignoring negative behavior whenever it does not present a threat to the child or others. Provide consistent redirection of behavior when a threat is present.

Assist other children in understanding and knowing ways of effectively interacting with the child by --

Using stories, puppets, and dramatic play to teach how to express positive and negative emotions, develop the vocabulary needed to speak about feelings, and modeling strategies for effective interaction when presented with adverse interpersonal situations.

Physical Disabilities

Definition

Physical Disability refers to motor function that is impaired. It may be caused by a variety of medical or structural conditions including the following: arthritis, cerebral palsy, muscular dystrophy, spina bifida, or spinal cord damage.

Characteristics

The nature and severity of a child's physical disability will affect the rate and capacity for attaining motor milestones. Some children may reach developmental milestones more slowly, while others will require adaptive equipment to facilitate alternate response modes. Because of impaired motor ability, some children will need extra assistance in developing independent self-help skills (i.e., independent mobility, eating, toileting, personal hygiene). Cognitive development may be delayed if the condition prevents the child from physically interacting with the environment (i.e., inhibiting sensori-motor experience contributing to learning and problem solving). Communication skills may be affected if the condition involves the control of muscles necessary for speech. Social/emotional development may be affected if the physical disability inhibits adult or peer interactions (i.e., "cuddling" during infancy or play transactions during early childhood).

Common Terms

orthopedic impairment
cerebral palsy
spina bifida
paraplegia
quadriplegia
positioning

Helpful Questions

Ask parents for instruction on how to use special equipment (e.g., wheelchairs, braces, artificial limbs, or other mechanical devices), along with their recommended methods for positioning, lifting and carrying.

Ask a physical or occupational therapist for help in making physical adaptation to the classroom environment and/or equipment, and for advice on proper positioning to maximize a child's full participation in individual and group activities.

Ask a speech/language specialist to assist in developing communication aids when helping a child develop alternative modes of communication is called for.

Helpful Strategies

Help the child to be as independent as possible by --

Allowing enough time for the child to respond. It may take longer for a child with a physical disability to speak or move.

Letting children do as much of a task as they can, before providing assistance.

Helping the child to learn to ask for assistance when it is needed to accomplish a task -- avoid "taking over" if a child does not want/request help.

Providing proper positioning, which will help the child be comfortable, well balanced, and aid both participation and concentration.

Providing adaptive equipment designed to help the child interact with the environment as much as possible.

Provide the child with lots of opportunities for success, by --

Arranging activities and materials so that minimal movements will produce an effect on the environment.

Providing open ended activities, so that children can complete their task according to their individual pace.

Providing toys and instructional materials that are large enough for children with fine-motor deficits to manipulate successfully.

Leaving enough space for easy mobility between furniture and floor activities, as well as keeping the floor dry and free of obstacles to prevent falls.

Assist other children in understanding and knowing ways of effectively interacting with the child, by --

Teaching children about the physical disability: including information on what the disability is, how the disability affects action in the environment (i.e., speaks more slowly, does not walk, etc.), what the mechanical aids are and how they are used to assist action in the environment (i.e., wheelchairs are used to move about the environment).

Helping other children to learn helpful relationship skills (i.e., as above) through use of teacher prompts and reinforcement.

Speech/Language Impairments

Definitions

Speech and Language Impairments: Speech Impairments refer to problems in the oral production of language. While Language Impairments may involve either the use of language (expressive) or the understanding of language (receptive). Speech problems are one of the most common developmental impairments, with some speech impairment occurring in approximately 2.8% of the population of children and adults ages 3-21 years. The cause of speech and language impairments is clearly broad and varied. Frequently speech/language impairments are a secondary complication of a primary disability (mental retardation, cerebral palsy, hearing impairment, cleft-lip/palate, learning disabilities, autism).

Characteristics

Because speech and language skills provide the primary vehicle for communication, a child with speech/language problems may become frustrated easily and begin to develop socioemotional problems and delayed pre-academic skills.

A child with a speech impairment may have difficulty with articulation, voice sounds or fluency:

Articulation	Voice Sounds	Rhythm
Distortion of sounds	Quality (hoarse, nasal breathing)	Hesitation
Substituting of sounds	Pitch (too high or low, monotone)	Repetitions
Omission of sounds	Intensity (volume too high or low)	Prolongation

A child with a language impairment may have problems with receptive or expressive language:

Receptive
(Comprehension)

-delayed language development
-poor listening skills: covers ears, lacks/avoids eye contact, turns away
-difficulty in following simple phrases, instructions, etc.
-inattentive, short attention span
-difficulty in classification, sequencing skills
-trouble remembering

Expressive
(Difficulty expressing ideas)

-delayed language development
-immature language: simple words and phrases, poor grammar, improper use of words
-uses either too many or too few gestures and sounds to communicate
-difficulty in describing objects or events without visual cues
-expresses ideas, but presentation is disorganized

Common Terms

articulation
voice quality
fluency
pitch

receptive/expressive language delay
echolalia
intensity

Helpful Questions

Consult with parents about having a speech/language assessment if impairments are prolonged and observed to be interfering with a child's functional development.

Ask speech/language specialists to identify specific activities that can be carried out in the day-care center to assist the child's speech/language development.

Helpful Strategies

Assist the child to be as independent as possible by:

> Allowing enough time for the child to speak -- do model appropriate speech/language but do not make the child repeat the correct speech, do not demand the child to talk, do not interrupt or rush the child, and do not complete the child's sentences for him/her.
>
> Implementing curriculum activities that provide opportunities to practice needed skills in various ways (e.g., dramatic play, puppets, stories expressing sequencing, etc.), that do not draw attention to the child's difficulty.

Provide lots of opportunities for success by:

> Obtaining the child's attention before speaking; using simple, uncomplicated language; modeling extended speech/language in natural, child-directed dialogue.
>
> Involving the child in short, satisfying experiences that accommodate short-attention spans, and provide opportunities for positive reinforcement.
>
> Involving parents and encouraging them to carry out parallel activities at home.

Appendix F

Local Service Agencies

NICHCY

National Information Center for Children and Youth with Handicaps
P.O. Box 1492, Washington, D.C. 20013
(703) 893-6061 (Local) (1-800) 999-5599 (Toll Free) (703) 893-8614 (TDD)
*SpecialNet User Name: NICHCY ** SCAN User Name: NICHCY*

CORRECTIONS? Please help us keep this sheet up-to-date. Send your corrections to NICHCY, Attn: Drawer C.

State Resource Sheet: Kentucky

STATE DEPARTMENT OF EDUCATION: SPECIAL EDUCATION

Linda Hargan, State Director
Dept. of Education
Office of Education for Exceptional Children
Capitol Plaza Tower, Rm. 820
Frankfort, KY 40601
(502) 564-4970

PROGRAMS FOR CHILDREN WTIH HANDICAPS: AGES 3 THROUGH 5

Maggie Chiara, Branch Manager
Planning & Interagency Branch
Div. of Early Childhood Svcs.
Office of Education for Exceptional Children
Capitol Plaza Tower, 8th Fl.
Frankfort, KY 40601
(502) 564-4970

PROGRAMS FOR INFANTS AND TODDLERS WITH HANDICAPS: AGES BIRTH THROUGH 2

Jim Henson, Part H Coordinator
Infant and Toddler Program
Dept. of Mental Health & Mental Retardation Svcs.
275 E. Main St.
Frankfort, KY 40621
(502) 564-7700

STATE VOCATIONAL REHABILITATION AGENCY

Carroll Burchett, Associate Superintendent
Office of Vocational Rehabilitation
Department of Education
Capitol Plaza Tower, 9th Fl.
Frankfort, KY 40601
(502) 564-4566

OFFICE OF STATE COORDINATOR OF VOCATIONAL EDUCATION FOR HANDICAPPED STUDENTS

Donnalie Stratton, Unit Director
Special Vocational Programs Unit
Capitol Plaza Tower, Room 2134
Mero St.
Frankfort, KY 40601
(502) 564-3472

STATE MENTAL HEALTH AGENCY

Dennis D. Boyd, Commissioner
Dept. for MH/MR Services
Cabinet for Human Resources
275 East Main St.
Frankfort, KY 40601
(502) 564-4527

STATE MENTAL HEALTH REPRESENTATIVE FOR CHILDREN AND YOUTH

Margaret Pennington, Manager
Children & Youth Scvs. Branch
Dept. for MH & MR Svcs.
Health Services Bldg.
275 East Main St., lst Fl. East
Frankfort, KY 40621
(502) 564-7610

STATE MENTAL RETARDATION PROGRAM

Charlie Bratcher, Director
Div. of Mental Retardation
Dept. for Mental Health & Mental Retardation Svcs.
275 East Main
Frankfort, KY 40621
(502) 564-7700

STATE DEVELOPMENTAL DISABILITIES PLANNING COUNCIL

Prudence Moore, Director
Kentucky DD Planning Council
Dept. For Mental Health/Mental Retardation Services
275 East Main St.
Frankfort, KY 40621
(502) 564-7842

PROTECTION AND ADVOCACY AGENCY

Gayla O. Peach, Director
Office For Public Advocacy
Division for P&A
Perimeter Park West
1264 Louisville Rd.
Frankfort, KY 40601
(502) 564-2967
(800) 372-2988 (In KY)

CLIENT ASSISTANCE PROGRAM

Sharon S. Fields, Director
Client Assistance Program
Capitol Plaza Tower
Frankfort, KY 40601
(502) 564-8035
(800) 633-6383 (In KY)

PROGRAMS FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

William Minix, Executive Director
Commission for Handicapped Children
Bureau for Health Services
Dept. of Human Resources
1405 E. Burnett Ave.
Louisville, KY 40217
(502) 588-4459

STATE AGENCY FOR THE VISUALLY IMPAIRED

Charles W. McDowell, Exec. Dir.
Dept. for the Blind
427 Versailles Road
Frankfort, KY 40601
(520) 564-4754

STATE EDUCATION AGENCY RURAL REPRESENTATIVE

Vivian Link, Associate Supt.
Dept of Education
Capitol Plaza Tower, 8th Fl.
Frankfort, KY 40601
(502) 564-4970

DISABILITY AGENCIES

Autism -
Alice Boyer, President
Kentucky State Society
Autism Society of America
P. O. Box 37011
Louisville, KY 40232
(502) 561-5678

Cerebral Palsy
Mary Lou Strait, Exec. Dir.
United Cerebral Palsy of Eastern Kentucky
Diniaco Ct., P.O. Box 413
Ashland, KY 41105-0413
(606) 324-1614

Learning Disabilities
Debbie Troutman, Pres.
Learning Disabilities Assn. of KY
Box 13 B
Battletown, KY 40104
(502) 497-4643

Mental Health
Mr. Dixie Kimberlin, Exec. Dir.
Kentucky Mental Health Assn.
400 Sherburn Lane, Suite 357
Louisville, KY 40207
(502) 893-0460

Chuck Marlatt, Pres.
KY Alliance for the Mentally Ill
P.O. Box 5367
Louisville, KY 40205
(502) 896-1877

Mental Retardation
Patty Dempsey, Exec. Dir.
Assn. for Retarded Citizens/KY
833 East Main
Frankfort, KY 40601
(502) 875-5225

Speech and Hearing
Mary Gray, President
KY Speech-Language-Hearing Assn.
P.O. Box 4098
Lexington, KY 40544
(606) 277-2446

Spina Bifida
Spina Bifida Assn. of Kentucky
982 Eastern Parkway, Box 18
Louisville, KY 40217
(502) 637-7363

UNIVERSITY AFFILIATED PROGRAM

Melton C. Martinson, Director
Interdisciplinary Human Development Institute
University Affiliated Facility
University of Kentucky
114 Porter Bldg.
730 S. Limestone
Lexington, KY 40506-0205
(606) 257-1714

PARENT TRAINING INFORMATION PROJECT

Paulette Logsdon, Director
Kentucky Special Parent Involvement Network (KY-SPIN)
318 West Kentucky St.
Louisville, KY 40203
(502) 589-5717 or (502) 584-1104
(800) 525-7746

PARENT-TO-PARENT

Jenny Mayberry, Director
Directions Service Center
Blue Grass Area Chapter of Am. Red Cross
1450 Newtown Pike
Lexington, KY 40511
(606) 233-9370

OTHER ORGANIZATIONS

Guion F. Miller, Executive Dir.
Kentucky Easter Seal Society
233 East Broadway
Louisville, KY 40202
(502) 584-9781

AGE OF ELIGIBILITY

Each state sets eligibility ages for services to children and youth with disabilities. For current information concerning this state, please contact the office listed under STATE DEPARTMENT OF EDUCATION: SPECIAL EDUCATION.

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UPDATE 7/90

For more information contact NICHCY.

Appendix G: Integrated Services

Appendix H: Child Care Environment

Appendix I: Health and Safety Records

Appendix G

Integrated Services

Source: Multiple sources were used to develop this module and are identified in parenthesis as cited in the reference.

INTEGRATED SERVICES

It is quite clear that consistent, sustained, and well-conceived interactions between nonhandicapped and young children with handicaps can improve both the social and communicative performance of children with handicaps (see Strain et al., 1986, for extensive reviews). There are also positive reactions for the nonhandicapped children that continue into their later years (in Robinson, 1988). Moreover, there is evidence that inconsistent, unsustained, and ill-conceived interchanges between nonhandicapped and children with handicaps are developmentally insignificant (Strain & Odom, 1986).

Numerous administrative arrangements can lead to developmentally significant integrated services including: (a) enrollment of children with handicaps in appropriate family- or center-based day care or preschool; (b) enrollment of children with handicaps in Head Start; (c) enrollment of nonhandicapped children in specialized programs; and (d) enrollment of children with handicaps in school-sponsored preschools and kindergartens. None of these setting arrangements by themselves lead directly to developmentally significant programming. That can be achieved only when children share an instructional and social environment and when teachers and children are specifically trained to facilitate interaction (Strain & Cordisco, 1983).

Not only is integration a central issue for early childhood service models, but it is just as relevant to the future placement of the program graduates. If placement in nonsegregated settings is to have meaning beyond the early childhood years, early childhood special education professionals must be involved in retraining regular education personnel. In the next decade, we must be willing to share knowledge, techniques, and methodology that have proven to be effective with administrators, teachers, and related personnel in regular education. The logistical and fiscal enormity of such an enterprise must not be underestimated. However, if early childhood special educators wish to "move" children and families to regular class options, we must be sure worthwhile options are available (in Smith & Strain, 1988). ☐

Source:
Federal Resource Center. (1990). Shaping
the future: Free and appropriate public education
for preschool children with special needs.
Lexington: U.K. IHDI

RATIONALE for INTEGRATION

Psychological

- if children are separated from one another at an early age, how can we expect these children to grow into adulthood respecting and valuing one another
- an environment which emphasizes human diversity stimulates intellectual, social and emotional growth
- we are cheating normally developing children when we do not expose them to the great diversity that exists in our society
- few aspects of a child's life are more important than sharing normal educational experiences with children of his/her own age
- integration reduces the fear of difference, promotes friendships and understanding, leads to acceptance and tolerance and increases self-esteem and self-confidence

Educational

- when diversity in the classroom is identified and valued, the quality of teaching improves for all
- curriculum is not deficit-oriented, therefore offers a wider range of individualized learning experiences and an exposure to higher personal expectations
- offers opportunities for the handicapped child to learn socially appropriate behavior through imitation and modeling
- offers opportunities for the handicapped child to learn to function in normal life situations in natural environments and under normal conditions
- an integrated environment provides both natural and age-appropriate prompts, reinforcements and consequences therefore leading to greater acquisition, maintenance and generalization of skills

Philosophical

- integration is a basic human right
- ethical principles are identical to those proposed by advocates of racial, ethnic, cultural and sexual equality
- reflects human concern for human beings
- a means for reducing isolation and prejudice while enhancing an understanding and acceptance of differences

Socio-Cultural

- increases the potential contribution of handicapped individuals to society at large
- if a child is segregated at an early age the tendency is to stay there; ultimately costly to society as the individual becomes dependent on society
- if we do not want people to live in institutions we must teach them the skills necessary to communicate, interact, work and recreate

  these skills can best be taught in natural, age-appropriate and integrated environments

Political/Legal

- ensures quality of educational opportunity and equal protection under the law
- given its legal-constitutional basis it cannot be seen as just a fad
- if the rights of any are diminished, so are, in the long run, the rights of all

INTEGRATION..........Who Benefits?

BENEFITS FOR THE HANDICAPPED CHILD:

Can learn in a stimulating environment which focuses more on strengths than weaknesses.

Have opportunities to develop friendships/relationships which can have long term impact on their lives.

Helps prepare children for the "real world".

Competent and appropriate models (non-handicapped children) should facilitate development of social and communicative skills in handicapped children.

Exposure to increasingly complex environmental demands should facilitate developmental progress - this is most apt to occur in mainstreamed settings.

Have the opportunity to learn skills in the environment where they are needed.

Children are more likely to be accepted by the broader community if they are placed in "normal" settings.

BENEFITS FOR THE NON-HANDICAPPED CHILD:

Have opportunities to develop positive and realistic attitudes toward handicapped people.

Can learn in an environment which emphasizes strengths and and accepts limitations

Many are possibly the future parents or service providers for handicapped people.

They come to realize the value of individual differences.

Perspective - Presence provides valuable social, emotional and personal perspectives that could not otherwise be realized.

They may become more accepting of their own limitations.

Handicapped children provide good models for striving or coping despite adversity.

BENEFITS FOR FAMILIES OF HANDICAPPED CHILDREN:

May develop more positive attitudes toward their handicapped child.

Provides a "real world" perspective for interpreting child's accomplishments and limitations.

Improved knowledge of normal child development.

May encourage families to provide more chronologically age-appropriate activities for their child.

May result in improved perceptions of self as parent.

May result in reduced feelings of social isolation.

BENEFITS FOR FAMILIES OF NON-HANDICAPPED CHILDREN:

Provides an experiential basis for teaching their own children about differences in growth and development.

May provide greater understanding of handicapped persons.

May provide greater sensitivity to needs of families with handicapped children.

May become future advocates of normalized programs.

BENEFITS TO EARLY CHILDHOOD AND SPECIAL EDUCATORS:

Can learn new skills from each other (for example: identification of special needs, individualized programming, facilitation of social development and classroom management).

Experience teaching support through the use of ancillary and support services.

Opportunity to broaden knowledge base in early childhood and special education.

BENEFITS TO ADMINISTRATORS:

Have increased classroom and staff resources.

May have a more cost-effective approach to special services.

Will see increased staff skills through additional inservice opportunities.

Wolery et al.

Appendix H:

Child Care Environment

Early Childhood Behavior
FUNCTIONAL ANALYSIS RECORD

Functional Analysis Guidelines:

1. To identify the setting in which the behavior is likely to occur, informal observation is needed before the functional analysis begins. If a behavior has only occurred once or twice, formal intervention is probably not called for.
2. Record only factual observed behaviors under sections A:B:C below - the comments section can be used to record teacher interpretations of behaviors, to make notes comparing one observation to another, etc.
3. Before beginning to generate hypotheses about function/behavior relationships, always conduct a series of observations of the behavior, under similar conditions, for a period of at least one week.
4. After summarizing the behavior sequence, review categories of functional behavior to identify the possible function(s) of the behavior sequence.
5. Plan intervention strategy related to a) the identified function of the behavior sequence, and b) the behavior targeted for change (e.g. the desired behavior).
6. Conduct and record observations during the implementation of the planned intervention strategy.
7. Monitor outcomes (e.g. Has the desired behavior been developed and the inappropriate behavior diminished?)
8. Review and modify intervention plan, as needed.

Summary Observation Record:

Child's name:_______________**Recorders name:**______________

Date(s) of Observation:__________________

Behavior being observed:__________________________________

____

Setting: ____

____

____

Time: ______(start of observation) - ______(end of observation).

A **Antecedent** (Before)	**B** **Behavior** (During)	**C** **Consequence** (After)

Recorder Comments:

Function - Behavior Relationships

Target Behavior (behavior you want a child to develop): _______

____

____

Summary of behavior sequence (behavior you want to change) -

Antecedent : ____

____

Behavior: ____

____

Consequence: ____

____

Possible Function/Behavior Relationships -

Behavior Function	Rationale
1.	
2.	

Planned Intervention Strategies

1. **Antecedent Strategy:** ____________________

____

____

____

2. **Teaching Strategy:** ____________________

____

____

____

3. **Consequence Strategy:** ____________________

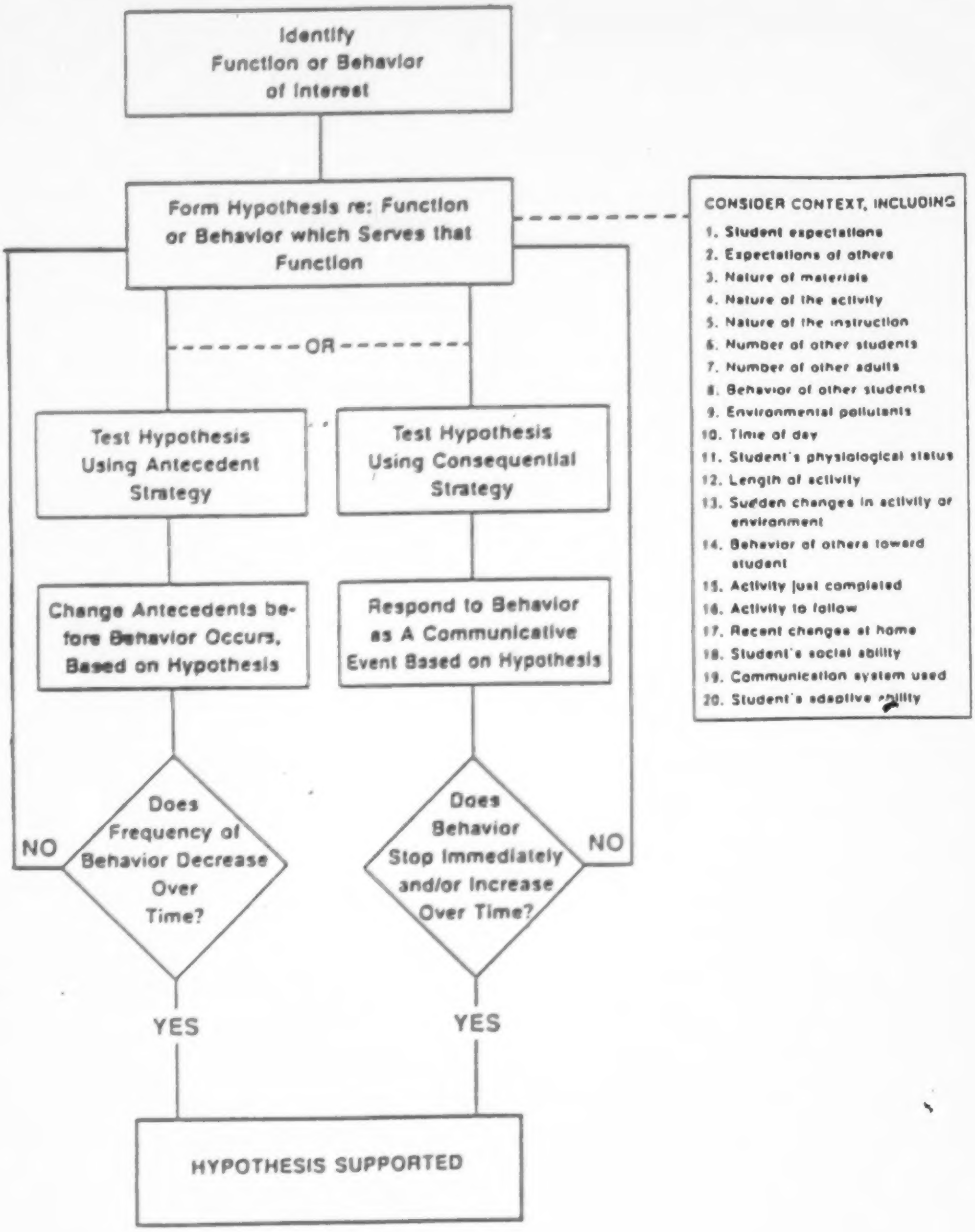
____

____

____

Observation Record of Planned Intervention :

Outcome Statement:


Identify Function or Behavior of Interest
Form Hypothesis re: Function or Behavior which Serves that Function
CONSIDER CONTEXT, INCLUDING
1. Student expectations
2. Expectations of others
3. Nature of materials
4. Nature of the activity
5. Nature of the instruction
6. Number of other students
7. Number of other adults
8. Behavior of other students
9. Environmental pollutants
10. Time of day
11. Student's physiological status
12. Length of activity
13. Sudden changes in activity or environment
14. Behavior of others toward student
15. Activity just completed
16. Activity to follow
17. Recent changes at home
18. Student's social ability
19. Communication system used
20. Student's adaptive ability
OR
Test Hypothesis Using Antecedent Strategy
Test Hypothesis Using Consequential Strategy
Change Antecedents before Behavior Occurs, Based on Hypothesis
Respond to Behavior as A Communicative Event Based on Hypothesis
Does Frequency of Behavior Decrease Over Time?
Does Behavior Stop Immediately and/or Increase Over Time?
NO
NO
YES
YES
HYPOTHESIS SUPPORTED

A strategy for analyzing the communicative functions of behavior.

Source:
Donnellan, A.M., Mirenda, P.L., Mesaros, R.A., Fassbender, L.L. (1984). Analyzing the communicative functions of abberrant behavior. JASH, 9.

DEFINITIONS OF FUNCTIONAL CATEGORIES

I. INTERACTIVE FUNCTIONS

A. Requests

for attention - behaviors used to call attention to sender (e.g., showing off, teasing, flirting, etc.)

for social interaction - behaviors used to initiate a social exchange

for play interactions - behaviors that convey a desire on the part of the sender to engage in play with another person

for affection - behaviors that direct the receiver to engage in some physical activity specifically intended to convey a feeling of fondness

for permission to engage in an activity - behaviors that convey a desire on the part of the sender to engage in a particular action (e.g., bathroom, watch TV, etc.)

for action by receiver - behaviors that direct the receiver to cause an event to occur

for assistance - behaviors that direct the receiver to provide help

for information/clarification - behaviors that direct the receiver to provide information or clarification about an object, action, activity, location, etc.

for objects - behaviors that direct the receiver to provide an object to the sender (other than food)

for food - behaviors that specifically convey a desire for food or drink

B. Negations

protest - behaviors that express general objection to or disapproval of an event, request, etc.

refusal - behaviors that specifically express rejection of an event initiated or suggested by another

cessation - behaviors that specifically express a desire to terminate an event which has already begun

C. Declarations/Comments

about events/actions - behaviors that are used to comment on an event or occurrence (past, present, or future)

about objects/persons - behaviors used to comment about an object (including food), or about a person (e.g., compliments)

about errors/mistakes - behaviors that convey acknowledgement that the sender or another person has committed an error

affirmation - behaviors that convey agreement about or willingness to engage in an event or action

greeting - behaviors that occur subsequent to a person's entrance or appearance and express recognition

humor - behaviors intended to entertain the receiver and/or to evoke a response such as laughter

II. NON-INTERACTIVE FUNCTIONS

A. Self-regulation

behaviors used for the purpose of monitoring one's own behavior (e.g., self-control, self-correction)

B. Rehearsal

behaviors used to practice an event that has not yet occurred

C. Habitual

behaviors set by regular repetition in a predictable sequence

D. Relaxation/Tension Release

behaviors used for the purpose of self-entertainment or to calm oneself

Frequency Recording

Raw Data Sheet

Name: ____________________ Teacher/Trainer: ____________________

Phase: ______________ Behavior: ______________________________

Record each occurrence with a tally mark.

……

Date: ____________ Observation time: ____________________

Setting: ____

Data: ____

Total #: ________________ Rate: ____________________

……

Date: ____________ Observation time: ____________________

Setting: ____

Data: ____

Total #: ________________ Rate: ____________________

……

Date: ____________ Observation time: ____________________

Setting: ____

Data: ____

Total #: ________________ Rate: ____________________

……

Date: ____________ Observation time: ____________________

Setting: ____

Data: ____

Total #: ________________ Rate: ____________________

……

Date: ____________ Observation time: ____________________

Setting: ____

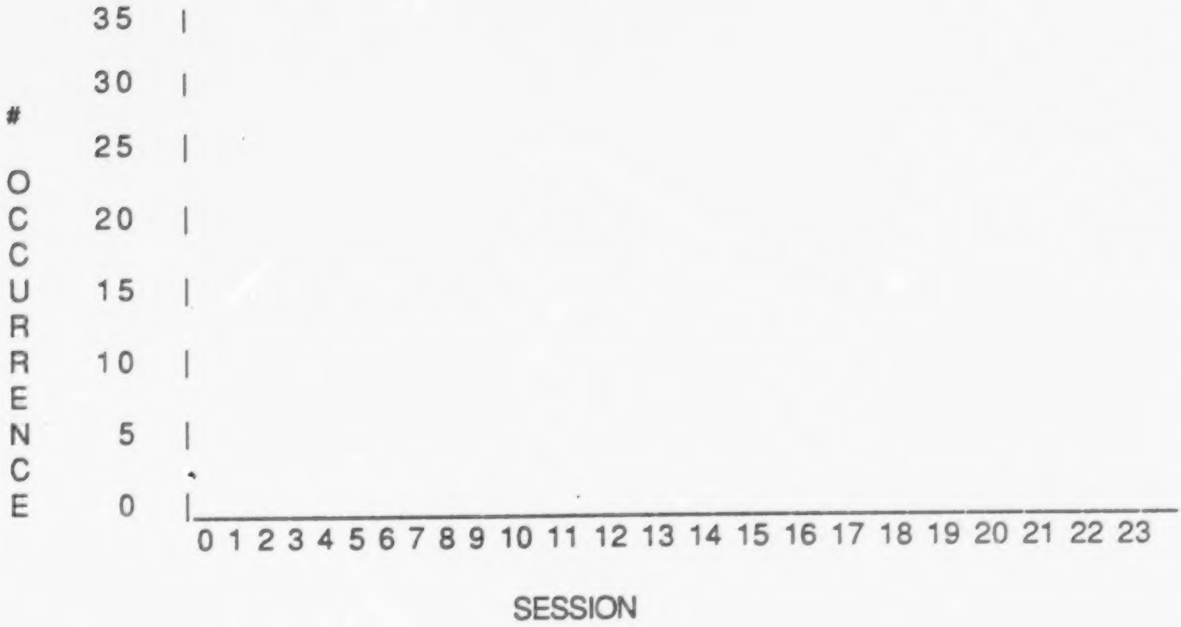
Data: ____

Total #: ________________ Rate: ____________________

……

Frequency Recording

Summary Sheet



Name: ______________________________

Teacher/Trainer ______________________

Objective:

DURATION RECORDING

Raw Data Sheet

Client ______________________ Caregiver ______________________

Target Behavior ____

With a stopwatch, measure the duration of each occurrence.

……

Date __________ General time of day __________ Setting __________

Duration ____

Total Duration ______________

……

Date __________ General time of day __________ Setting __________

Duration ____

Total Duration ______________

……

Date __________ General time of day __________ Setting __________

Duration ____

Total Duration ______________

……

Date __________ General time of day __________ Setting __________

Duration ____

Total Duration ______________

……

Date __________ General time of day __________ Setting __________

Duration ____

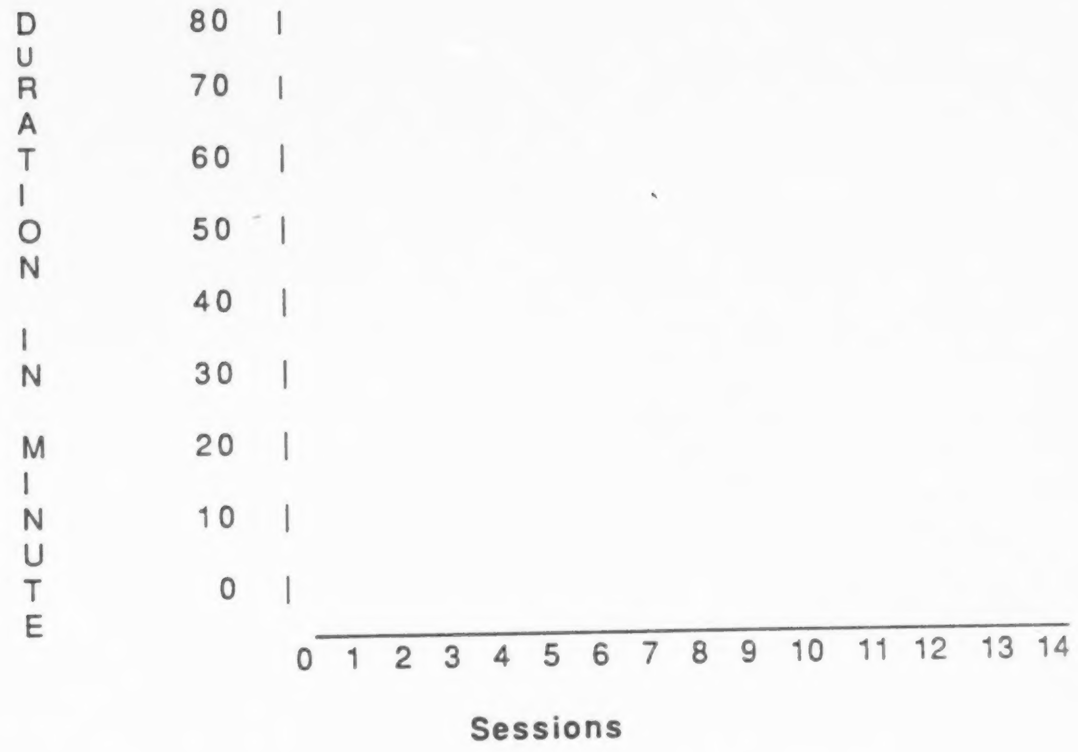
Total Duration ______________

……

DURATION RECORDING

Summary Sheet

Graphing:



Client: ______________________________

Caregiver: ___________________________

Objective:

Time Sample

Raw Data Sheet

Name: ____________________ Teacher/Trainer: ____________________

Date: ________________ Behavior: ______________________________

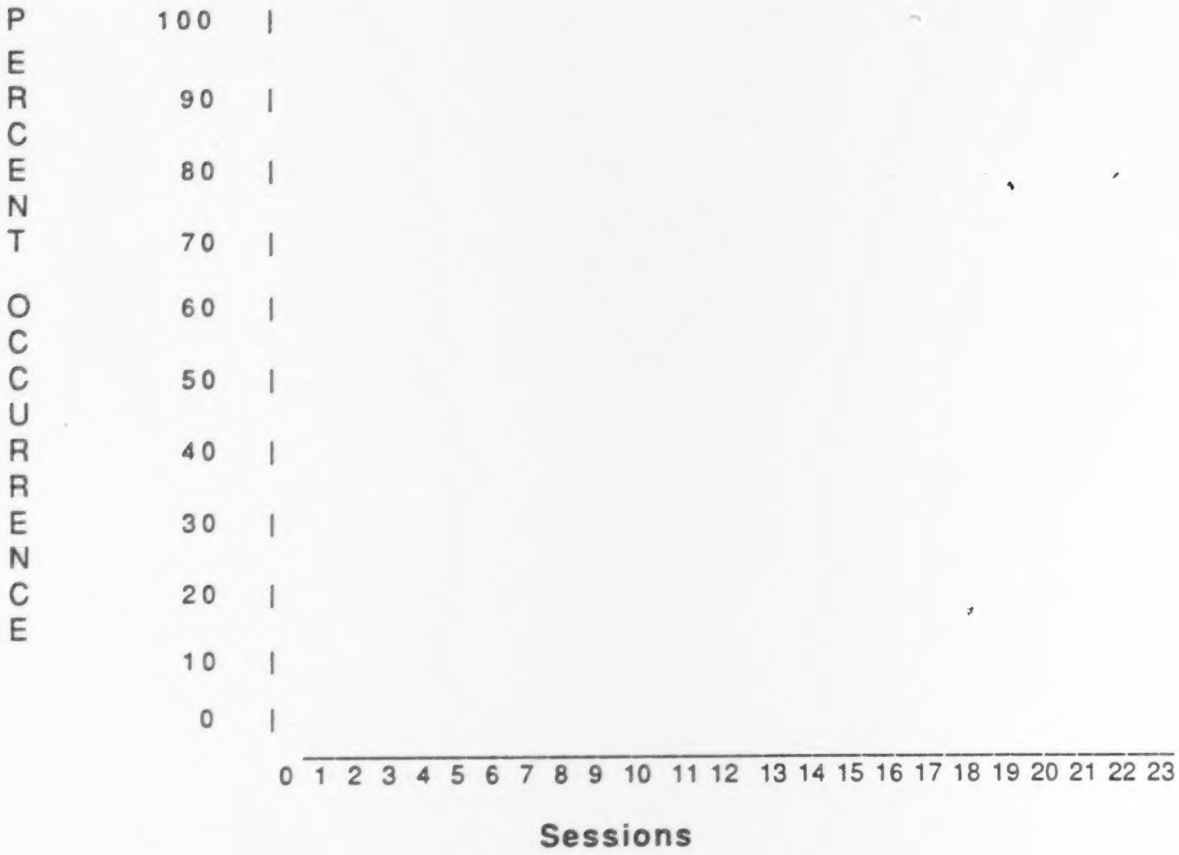
Setting: ____

Starting time: ________ Ending time: ________ Total time: ________

Time Interval Schedule: ____________________

Time Sample

Recording Summary Sheet



Name: ____________________

Teacher/Trainer: ____________________

Objective:

A ANTECEDENT	B BEHAVIOR	C CONSEQUENCE

Appendix I

Health and Safety Records

Supplement to Medical Examination Report
(Addendum for Children With Disabilities)

Confidential Information

Child's Name: ____________________

To the Parent or Physician:

As required by 905 KAR 2:010, Standards for child care facilities, our child care program is required to keep each child's medical history, on file from the date of enrollment. This form is a supplement to this information. Please have this form completed and attach to a copy of your child's medical history. Return to the center director by (date) ____________________ .

To be completed by parent or guardian:

Name of Child ____

Name of Parent or Guardian: ______________________________

Address: ____

School District: ____

Birth Date of Child: _____________________________________

To be completed by the child's physician:

Diagnosis (indicating a disability): ________________________

____

Any special limitations on activity: ________________________

____

____

Any physical or behavioral symptoms or concerns of which our staff should be aware: ____

____

____

Any prescribed medication or dietary limitations which will need to be followed by our staff: ____

____

____

Other Comments: ____

____

____

Signature of Examining Physician ____________________ Date: _____

Address: ____________________

Signature of Parent or Guardian: ____________________ Date: _____

____

Do Not Write in This Area

Record of Center Action (to be completed by child care center director).

Medical Authorization Form

To the Parent and Physician

As required by 905 KAR 2:010, Standards for child care facilities, our child care program must observe specific procedures and safeguards for administering medications. These procedures include the following:

- No medication can be given to a child except as prescribed by a duly licensed physician and/or written daily request of the parent or guardian.
- The center shall keep a written record of the administration of each medication, including time, date and amount.
- Medication shall be properly labeled and stored in a separate place out-of-reach of children.
- Prescriptions shall be in the original bottle and properly labeled.
- At no time will a medication be given to a child if the expiration date on the bottle has passed.

Please complete the following information, to be updated as necessary throughout the year.

Request for child care center to administer medication to (child's name)___________________________.

Date	Medication	Procedure	Parent Signature

Date	Medication	Procedure	Parent Signature

Early Childhood Center Safety Checklist

Instructions:

1. Review each item in the safety checklist and circle the number which best describes your child care setting - 1). Yes - Safe; 2). No - Needs Attention; 3). Uncertain - Need to Check.
2. After completing the safety check, complete the Safety Follow-up Form, describing 1) what action will be taken to address the safety need, and 2) the date the action was taken.
3. The center safety check should be completed monthly, and records maintained by the Center Director.

Outdoor Safety

Date: ______________

Staff Member: ________

All outdoor play areas are fenced with gates secured with child-proof latches.	1	2	3
All standing outdoor play equipment is securely installed with concrete fittings.	1	2	3
All outdoor climbing or other large play equipment has a soft surface underneath.	1	2	3
All outdoor play equipment is in good repair.	1	2	3
A tricycle path is clearly designated and separate from the general play area.	1	2	3
Appropriate adult child ratios are maintained to supervise groups of children on the playground.	1	2	3
Animals are not allowed to enter the playground area.	1	2	3
Sandboxes are covered when playground is not in use to prevent contamination by animals.	1	2	3
At least 8 feet is maintained between playground equipment.	1	2	3
Stairs, porches, and lofts have railings and non-skid surfaces.	1	2	3
There are no apparent safety hazards such as standing water, head entrapment areas (e.g. v-shaped angles), protruding nails or screws, or loose bolts (or other equipment joining methods).	1	2	3
Running water for clean-up and drinking is available to children.	1	2	3

Other:	1	2	3
Other:	1	2	3

Indoor Safety

Date: ______________
Staff Member: ________

Floors are smooth with a non-skid surface.	1	2	3
Floors, tables and other surfaces are cleaned daily, and as needed during child care hours.	1	2	3
All surfaces have rounded corners or rubber corner protectors in place.	1	2	3
All electrical outlets have safety plugs in place when not in use.	1	2	3
Electrical equipment is unplugged when not in use.	1	2	3
Hot water is maintained at 110-115 degrees or less.	1	2	3
Hot water pipes and heating equipment is are not accessible to children.	1	2	3
Medicines, cleansers and other potentially harmful substances are stored in locked closets.	1	2	3
All wall and ceiling surfaces are clean and in good repair.	1	2	3
Paint on all surfaces is non-toxic/lead free.	1	2	3
All windows have screens that remain in place, and windows do not open more than 5 inches.	1	2	3
Doors to unused areas of the facility, or areas off-limits to children remain closed with child-safe latches.	1	2	3
All doors to closets, bathrooms, or other areas accessible to children can be opened by children.	1	2	3
Diapering areas are right next to a source of running water, and there is a self-closing container for soiled diapers.	1	2	3
Child-size sinks and toilets are used in children's bathrooms.	1	2	3
Child-size sinks are available in classroom area.	1	2	3

Trash containers have covered lids.	1	2	3
Rooms are well lit and well ventilated at all times.	1	2	3
There is no sign of rodents or roaches in the facility.	1	2	3
Appropriate adult -child ratios are maintained among groups of children at all times.	1	2	3
Other:	1	2	3
Other:	1	2	3

Equipment and Toys

Date: ______________
Staff Member: ________

Projectile toys (darts, guns etc) and balloons are not allowed in the child care setting.	1	2	3
Small manipulative toys or toys with small removeable parts are not allowed in infant-toddler settings.	1	2	3
All toys and equipment are in good repair.	1	2	3
All toys are sterilized/disinfected at least weekly.	1	2	3
Infant toys that are put in the mouth are disinfected between use by different children.	1	2	3
Toy storage containers are open or ventilated.	1	2	3
Hinges and joints are protected to avoid fingers being caught.	1	2	3
Toys are non-toxic and nonflammable.	1	2	3
Toys which require adult supervision are kept separate from free-play toys.	1	2	3
Water tables are cleaned with a bleach solution and refilled daily.	1	2	3
Riding toys are stable, and have non-skid handgrips and peddles.	1	2	3
Climbing apparatus are placed on a soft surface.	1	2	3
Top-heavy equipment is securely bolted to the floor.	1	2	3
Tables and chairs are child-size and in good repair.	1	2	3

Cots are available for each child at nap-time.	1	2	3
Crib slats have no more than 2 3/8 inch space between them and mattresses fit snugly and are water-proof.	1	2	3
Soft pillows or toys are not put in cribs or playpens with infants.	1	2	3
Other:	1	2	3
Other:	1	2	3

Kitchen and Food Handling

Date: ______________
Staff Member:________

The kitchen area is off-limits to children, with a door closing off the area from child access.	1	2	3
All staff using kitchen area have proper training in food handling.	1	2	3
A cleaning solution of 1 tablespoon chlorine bleach to one quart water is used to disinfect surfaces and kitchen utensils.	1	2	3
Cleaning products, medicines, and foods are each stored in different areas and in their original containers.	1	2	3
Adults wash hands before all food preparation.	1	2	3
Adults and children wash hands before handling food.	1	2	3
Perishable foods are stored in closed containers in a refrigerator, and are labeled.	1	2	3
Non-perishable foods are stored in closed, insect-protected containers and are labeled.	1	2	3
Food that is prepared for a meal but not eaten is thrown-out.	1	2	3
Trash is kept away from food preparation areas, and is emptied daily.	1	2	3
A fire extinguisher is available, maintained regularly, and all staff have been trained to use it.	1	2	3
Pesticides are applied only by a certified pest-control operator.	1	2	3

A dining area is provided with child size tables and chairs where children sit for meals.	1	2	3
High chairs for infants and toddlers have safety straps and are made of heavy plastic or non-porous metal which can be easily cleaned.	1	2	3
Other:	1	2	3
Other:	1	2	3

Transportation

Date: ______________
Staff Member: ________

Car seats meet federal standards for safety.	1	2	3
The parent has signed an authorization to transport the children.	1	2	3
Car seats used with children less than 20 lbs. should face backwards and be secured in the back seat of the car.	1	2	3
Car seats for children between 20-40 lbs.should face forward and be secured in the back seat of the car.	1	2	3
Adult seat belts, without the shoulder strap, should be used with children over 40 lbs.	1	2	3
Infant carriers should never be used as car seats.	1	2	3
Written authorization has been obtained from parent to approve a person ,other than the parent, to pick-up their child from the child care center.	1	2	3
Other:	1	2	3
Other:	1	2	3

Emergency Procedures

Date: ______________
Staff Member: ________

Each child care area/room has at least two emergency exits, kept clear of obstacles, with doors opening in the direction of exit.	1	2	3

The child care center has established emergency exit plans, and have regular emergency practice drills with staff and children.	1	2	3
In case of emergency evacuation, the center has a designated meeting place away from the child care sight.	1	2	3
Smoke detectors and other alarms are checked by an authorized service person regularly.	1	2	3
The child care center has established medical emergency procedures, and has posted emergency phone numbers by phones in child care areas.	1	2	3
Each parent has completed a medical emergency card for their child, which is kept in a card file kept in a standard location.	1	2	3
Adequate transportation is available for emergency situations.	1	2	3
Children are taught the difference between food and poisons.	1	2	3
The phone number for the local poison center is posted near the phone.	1	2	3
A bottle of syrup of Ipecac is kept in the center to induce vomiting if children ingest certain poisons.	1	2	3
There is always at least one staff person with children who has been trained in CPR for infants and children.	1	2	3
The first aid kit is checked for supplies regularly, and is kept in a standard place where it can be reached by child care staff.	1	2	3
A portable first aid kit is taken on field trips away from the center.	1	2	3
All staff understand their roles and responsibilities in case of emergency.	1	2	3
Center staff attend inservice training on childhood health and safety topics annually.	1	2	3
Other:	1	2	3
Other:	1	2	3

Health Policies

Date: ______________
Staff Member: ________

The child care center has written policies on the health management of children.	1	2	3
Admission records including medical history, special needs, emergency numbers, and a signed release for medical attention in case of emergency, are maintained for each child and updated annually.	1	2	3
A authorized release to administer medication is obtained from the parent before administering any medication, and maintained in the child's file.	1	2	3
A record of administering medication is maintained and signed by the staff person who has administered each dosage.	1	2	3
Staff have received training on the proper administration of medicine from a health consultant.	1	2	3
Immunization records are maintained for each child, and updated annually.	1	2	3
An injury incident log is maintained with a record of injury for individual children kept in the child's file.	1	2	3
A separate area is maintained for sick children until s/he can be picked up by a parent.	1	2	3
There is a standard procedure for notifying parents in case of an infectious disease outbreak.	1	2	3
Staff know the signs and symptoms of common infectious disease, and are taught appropriate methods to minimize risk of contagion.	1	2	3
The child care center has access to a medical consultant.	1	2	3
Basic health and safety concepts and techniques are taught to children.as part of the child care center curriculum.	1	2	3
Other:	1	2	3
Other:	1	2	3
Other:	1	2	3

Safety Follow- Up:

Area Needing Attention (describe action which needs to be taken to meet safety guideline).	Date of Action to Meet Safety Guideline:

Appendix J: Working With Parents

COMMON RESPONSES OF PARENTS WITH SPECIAL NEEDS CHILDREN

Common Behavior	Parents' Feelings/ Action	Preschool Workers' Response
Shock Disbelief Denial	- Denial of handicap - Pretend handicap is not there - Excuses for why child is having "trouble" - Shame, guilt, unworthiness - Overcompensate by intense training - Doctor "hoping" - visits to different doctors to find out what parent wants to hear	- Listen with acceptance - Assure that feelings are normal - Focus on working together with the child - Affirm child's strengths - Direct parents to sources of information, gently
Anger Resentment	- May become angry at seemingly insignificant things - Sounds envious of others - Verbally abusive to teachers or others that have taught or been part of the child's diagnosis - May take statements by professionals or others out of context and restate them to the child's advantage	- Listen with acceptance - There is no need to agree or give suggestions - Direct parents to sources of information - Affirm your acceptance of the child and focus on working together - Avoid giving examples of what others have done
Bargaining	- Work hard with the child, i.e., "If I work with him every day he will catch up." - Grasping fr straws (postponing acceptance of the child's handicap) i.e., "This is just a stage." "His eyes are crossed - when that's corrected he'll catch-up	- Listen with acceptance - Show caring for child and for the parents
Depression Discouragement	- May be more open to suggestion for helping the child - Mourn the loss of the image of "normal child" - Having a sense of helplessness, hopelessness	- Listen with acceptance - Avoid criticism or too much praise - May need to suggest support group, counseling or other local resources.
Acceptance Adjustment	- Realizes something positive can be done - Accepts whole child - Adjusts lifestyle - Recognizes needs of child - Learns new techniques	- Teach new training techniques - Praise progress - Encourage realistic expectations

Adapted from: Kantos, S., Dunham, J., et. al. (1987) Neighbor Care: Neighbor Care: Training Manual for Family Day Care (Grant No. 6008401382).

The Family-Focused Interview

Whatever the purpose of an interview with parents, whether it is the first orientation meeting or a meeting to resolve some "issue", two objectives must be accomplished in order for the interview to be effective:

1. Create a trusting and respectful relationship.

2. Gather information which addresses the objective of the interview.

Five phases are involved in the family-focused interviews process. Keeping written notes during the interview may be helpful, however, the emphasis needs to be on open discussion rather than a formal data collection process. Always allow sufficient time following the interview to write down information, outcomes, activities, and time frames discussed during the interview.

Five Phases of the Family Interview Process:

a) PREPARATION

Consolidate and summarize family/child information related to objective.

Note information discrepencies or gaps that the interview can clarify.

Clearly recognize and clarify both the family and interviewers goals.

b) INTRODUCTION

Confirm the purpose, format, and structure of the interview

1. The purpose of the interview
2. The time allotted
3. The format to be followed
4. Confidentiality and procedural safeguards
5. Structuring the physical environment to facilitate process

c) INVENTORY

Validate and elaborate on the information already gathered.

Convey to the family that you are there to listen rather than advise.

Let the family do most of the talking.

Use effective communication skills to guide the interview process.

d) **OUTCOME SETTING**

Confirm that all topics and issues of relevance have been covered.

Briefly summarize what has been discussed.

Ask the family if they agree with the summary.

Assist family to identify and develop meaningful outcomes.

e) **CLOSURE**

Express appreciation for the families time and effort.

Make plans for future meetings.

Restate strategies and activities to be carried out before next meeting.

Give the family an opportunity to reflect on feelings about interview.

Adapted from: The IFSP Family focused IFSP Training Project, IFSP Training Guide, University of Kentucky.

FAMILY NEEDS SOLVING APPROACH

The Family Needs Solving Approach has good potential for use in the development of IFSP's. Some major benefits include:

1. Life-Long Skill.

Joining families in a family problem or needs solving approach gives them skills in solving their own problems that they can take with them through life. It is one of the most important transition skills we could teach.

2. Family-focused.

Often times professionals see their role as solving problems, providing the answer, and providing knowledgeable information. But sometimes professionals don't know the answer. If they do know the answer it is from their value perspective, not the family's perspective. This approach assists families in clarifying their own need, generating family referenced alternatives, and identifying their own strengths to meet those needs. The focus is on what the family needs, not on what the professional or agency has to offer.

3. Empowerment.

The control a family has over the environment can play an important role in creating a positive response to stressful events. This process can assist families in gaining a greater sense of control over needs and problems. It gives them a skill that they can take to each new situation with greater confidence. Empowerment of families is seen as a major goal of case management and NSA can be used by case managers to achieve this goal.

4. Family Strengths Tied to Family Outcomes.

Each family has a unique set of resources, perceptions, and strengths that they bring to meet a family need. This approach allows for family resources and strengths to be explored for each alternative a family generates. Therefore, specific family strengths are used for the implementation of an alternative. This helps move past general and global statements of family strengths - to specific family strengths that can be used to meet the need.

FAMILY NEEDS SOLVING APPROACH

What's the Desired Outcome?

1. Gather information from interviews, observations, and assessment data.
2. Note any discrepancies in information gathered.
3. Discuss the needs/concerns of each family member.
4. Describe how the situation is a need.
5. Translate the need into the desired child or family outcome.
6. Determine how other family members feel about the need.

What Can I Do?

1. Identify several alternatives for addressing the need, considering all possibilities.
2. Ask others for possible alternatives.
3. Obtain additional information for addressing the need(s).
4. Include ways that other family members can help.

Think It Over

Barriers to Alternatives

1. Consider what the barriers will be for each alternative for implementation.
    a. will it cost money?
    b. will it require asking others for help?
    c. will it require time?
    d. will it affect you personally?
    e. will it affect other family members?
2. Identify possible short term and long term effects.
3. Identify possible positive and negative effects of each alternative.

Resources and Strengths to Implement Alternatives

1. Identify personal and family resources and strengths.
2. Identify family perceptions, values, and priorities.
3. Identify friends and supports in the community.

Make A Decision

1. Families may want to rate alternatives by additional criteria, or just a thumbs-up or thumbs-down rating.
2. Select the alternatives for implementation. Allow for reflection.

Tasks To Do

1. Succinctly summarize what has been discussed.
2. Arrange for necessary resources and procedures.
3. Decide which persons will be responsible for which tasks, and how they will go about completing them.
4. Take necessary action.

How Did It Work?

1. Look back at original need and the goal and see if goal was met.
2. If goal was met, what needs to be done to maintain goal.
3. If goal was not met, review need to see if it was identified correctly. Review alternatives to see if they are being implemented according to action plan, or if any changes must be made in either alternatives selected or action plans. Make necessary modifications and proceed with the need solving components again.

FAMILY NEEDS SOLVING APPROACH

Parent Date

Service Coordinator

1. What's the need?
   (Identify Desired Outcomes)

2. What could I do? (Brainstorming)	3. Think it over. (Alternatives, Strengths, and Barriers)
a.	a.
b.	b.
c.	c.
d.	d.
e.	e.
f.	f.

4. Make a decision. (Select Alternatives and Specify Outcomes)

5. Tasks to do. (Procedures and Timelines)

6. How did it work? (Evaluation)

Appendix K: Interagency Collaboration

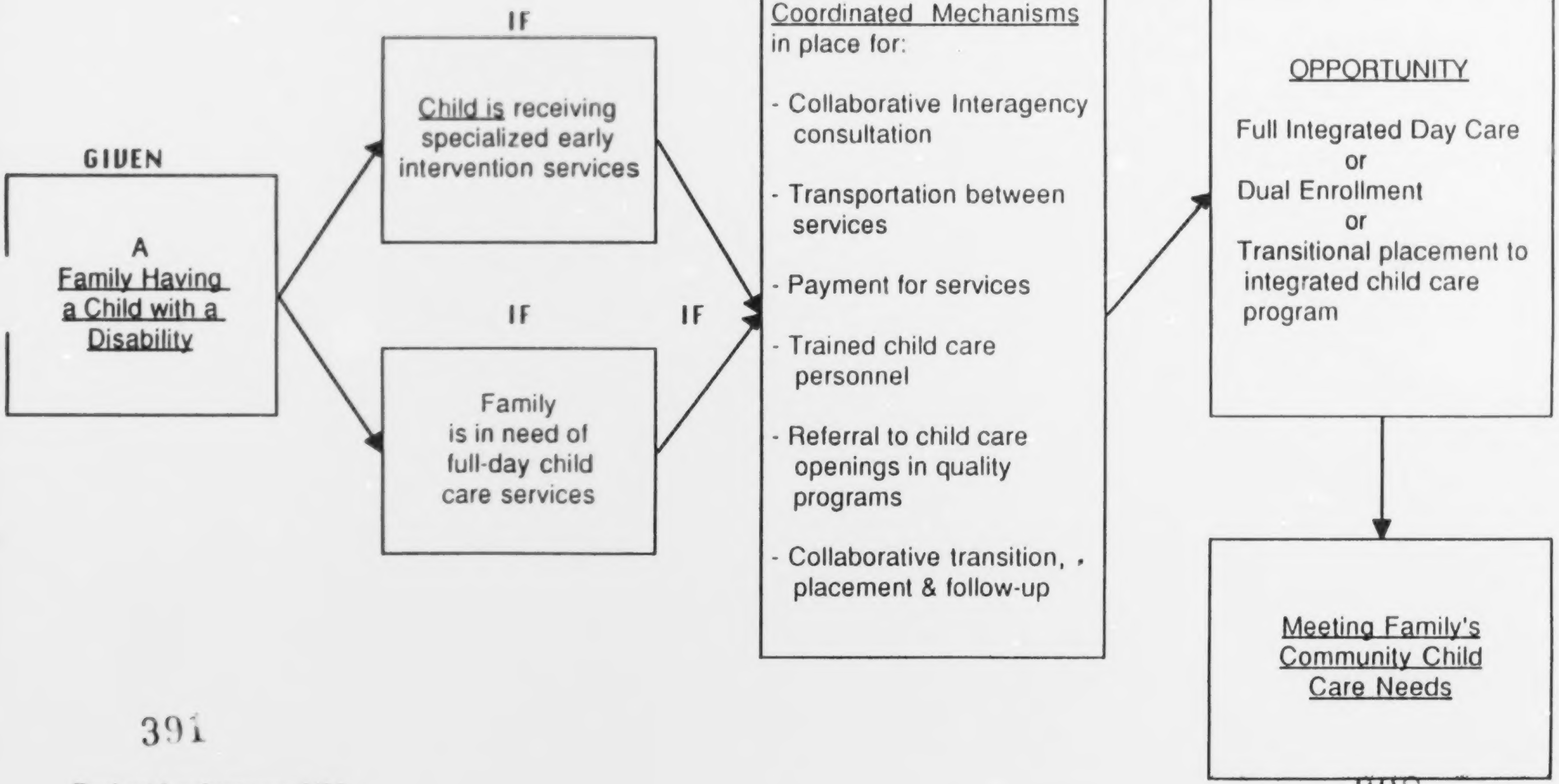
Appendix L: Screening Assessment, and IFSP/IEPs

Appendix K

Interagency Collaboration

EXPANDING OPPORTUNITIES

For Community Day Care Services to Families of Children with Disabilities



GIVEN

A Family Having a Child with a Disability

IF

Child is receiving specialized early intervention services

IF

Family is in need of full-day child care services

IF

Coordinated Mechanisms in place for:

- Collaborative Interagency consultation
- Transportation between services
- Payment for services
- Trained child care personnel
- Referral to child care openings in quality programs
- Collaborative transition, placement & follow-up

OPPORTUNITY

Full Integrated Day Care
or
Dual Enrollment
or
Transitional placement to integrated child care program

Meeting Family's Community Child Care Needs

Project Lexington: 6/90

Source: Multiple sources were used to develop this module and are identified in parenthesis as cited in the reference.

THE NEED FOR A COMPREHENSIVE SYSTEM OF SERVICES

Though P.L. 99-457 (Section 619) only requires special education and related services for preschool children ages 3 through 5, in reality, there is a need to create a comprehensive system of early childhood services including parent education and family support programs; child care; and health, social, and mental health services. If infants and toddlers are provided services through Part H programs, there will be a need for a transition into services for preschoolers. Public schools and other early childhood programs need to work together to build this system through joint planning, advocacy, and partnerships in sponsoring services. Just as public schools have developed partnerships with businesses and higher education institutions that accept their graduates, public schools and the early childhood community need to work together (in NASBE Task Force, 1988, p.1).

Given the realities of budgets, available staff and facilities, public schools, Head Start and other publicly funded early childhood programs will not be able to expand quickly enough to serve all preschool children in the near future. The present mix of for-profit, non-profit, church-based, family child care systems, and public school programs certainly will continue. And in fact there are real advantages to a mixed system of sponsorship, particularly in terms of providing choices for parents in the type, location, costs, and philosophy of setting they select for their children (in NASBE Task Force, 1988, p. 7).

A "one-size-fits-all" philosophy could have devastatingly negative consequences for the outcomes of early childhood programs since it ignores the following information:

- Children and families are different and consequently have different needs and will respond differently to programs.
- It may be that neither the cheapest nor the most effective program is the most cost-effective.
- Although many models of early education have been promoted, there are not yet sufficient research data available to make decisions about which model is most effective for which children (in White & Immel, 1988, p. 30). ☐

Source: Council of Chief State School Officers (CCSSO). (1989). A guide for state action: Early childhood & family education (pp.32). Washington, DC: Author.

REASONS FOR COORDINATION AND COLLABORATION OF SERVICES

State and local agencies have developed a number of coordinating and collaborating mechanisms for planning and providing comprehensive service delivery because:

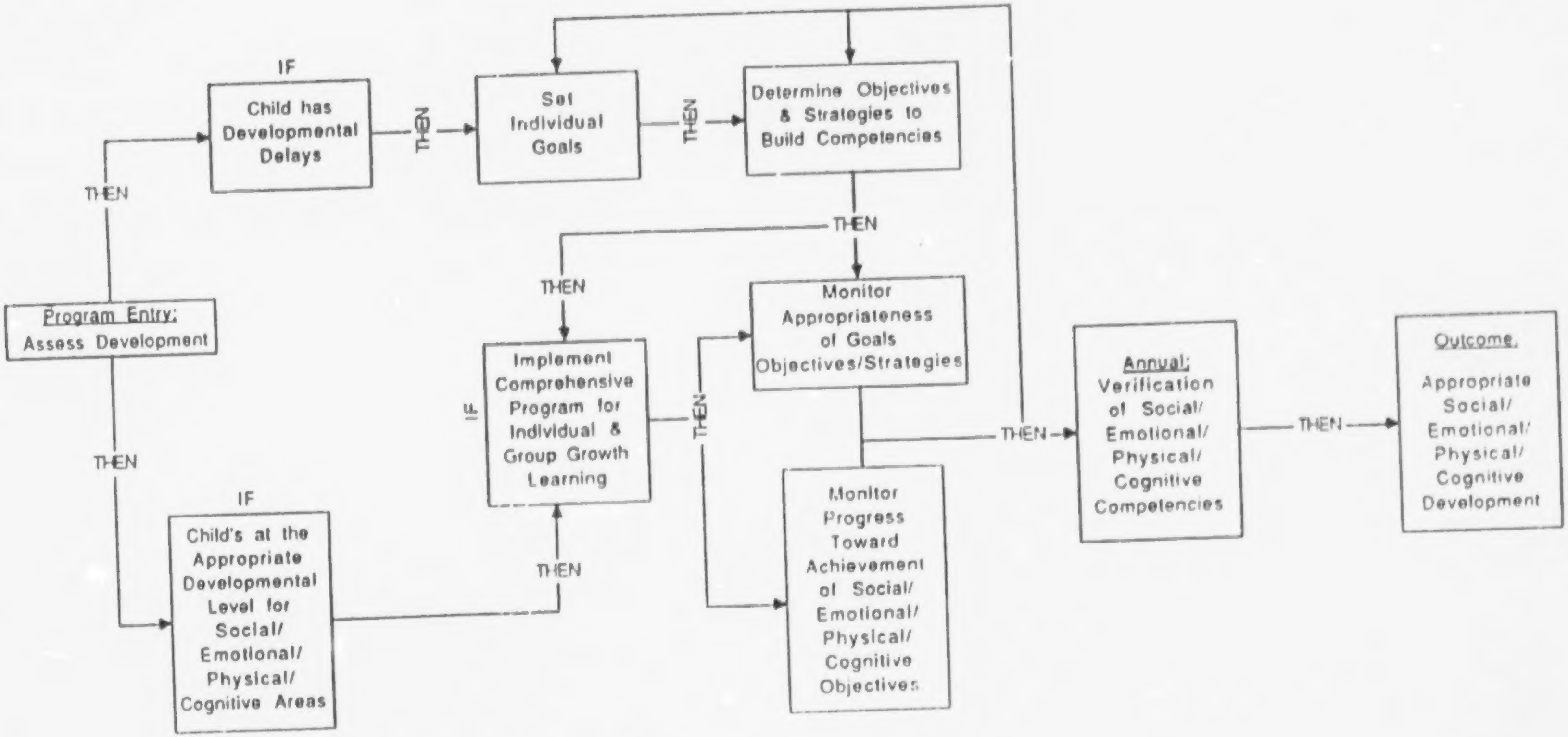
- increasingly this is required by state law;
- the executive branch often initiates cooperation among agencies;
- federal law is encouraging and often requires coordination of services;
- providers, advocacy, and parent groups are exerting pressure for better coordinated programs and policy;
- mounting evidence about the effectiveness of interventions aimed at child well-being rather than traditional definitions of child welfare, health, and education has caused a shift in thinking among professionals that encourages cooperative efforts (Petit, 1988).

There are numerous examples of comprehensive service delivery models currently in use by local and state agencies. They illustrate how delivery systems can be expanded to include the existing childhood ecosystem and how public and private agencies can work together to provide child and family services. ☐

Appendix L

Screening Assessment, and IEPs

Integrated Early Childhood Education
Developmental Service Model


Program Entry:
Assess Development
THEN
IF
Child has Developmental Delays
THEN
Set Individual Goals
THEN
Determine Objectives & Strategies to Build Competencies
THEN
THEN
IF
Child's at the Appropriate Developmental Level for Social/ Emotional/ Physical/ Cognitive Areas
THEN
IF
Implement Comprehensive Program for Individual & Group Growth Learning
THEN
Monitor Appropriateness of Goals Objectives/Strategies
Monitor Progress Toward Achievement of Social/ Emotional/ Physical/ Cognitive Objectives
THEN
Annual:
Verification of Social/ Emotional/ Physical/ Cognitive Competencies
THEN
Outcome.
Appropriate Social/ Emotional/ Physical/ Cognitive Development

PROJECT LEXINGTON
1991

TEAM APPROACH

1) Children with disabilities need extensive practice to learn new movement patterns.
Episodic intervention by occupational, speech language and physical therapists is not enough. Daily carry-over at home and in the classroom is essential.

2) It is essential that all team members (numerous people who handle, move, and position the child each day) provide consistent handling and continuity across settings.

3) The function of therapists is to teach principles of handling and positioning, specific to the needs of the child, to other team members.

4) The functional needs of the child in his or her natural environment are what drive the team.

5) Team members need to have therapists' consultations in the child's daily natural environment.

6) Family participation in the child's program plan is essential.

7) Emphasize the child's strengths.

RELATIONSHIP OF OCCUPATIONAL THERAPY AND PHYSICAL THERAPY IN THE SCHOOL SYSTEM

OCCUPATIONAL THERAPY

PHYSICAL THERAPY

MAIN AREAS OF EMPHASIS FOR EACH PROFESSION

Psycho-social, integration of sensory-perceptual, prevocational evaluations.

Motor development and function.

ALTHOUGH EACH PROFESSION HAS AN AREA OF EXPERTISE THEY MUST TREAT THE WHOLE CHILD SO SOMETIMES YOU WILL SEE:

Motor activities being utilized.

Psycho-social or sensory-perceptual intervention measures being utilized.

THE GOAL FOR BOTH PROFESSIONS IS THE ACHIEVEMENT OF OTPTIMUM FUNCTION WITHIN THE INDIVIDUAL'S ENVIRONMENT. WHEN TRAINING FOR FUNCTIONAL ACTIVITIES (activities for daily living) EACH PROFESSION TENDS TO HAVE MORE EXPERTISE IN THE FOLLOWING AREAS:

Dressing, hygiene, self-feeding, non-verbal communication.

ADAPTIVE EQUIPMENT AND SPLINTING

Positioning, handling, sitting, lifting and transferring, ambulating.

ORAL-MOTOR FUNCTION

↑

SPEECH THERAPIST

Approved By
Kentucky Occupational Therapy Association
and Kentucky Chapter American Physical
Therapy Association

Appendix M: Special Education Techniques

Appendix N: Project Lexington Resource Directory

Appendix M

Special Education Techniques

DEVISING EFFECTIVE CURRICULUM PLANS

The basic prerequisites for devising effective curriculum plans for children with disabilities in integrated child care settings include"

1. Knowledge of early-childhood development and methods for curriculum planning and implementation in generic early child care settings.

- **Write weekly/daily classroom schedules that specify age-appropriate activities for routine time-periods and activity areas.**
- **Provide for a range of developmental skill levels within activities.**
- **Observe how children interact within the arranged environment, providing individual assistance or environmental adaptations as needed to encourage optimal skill development.**
- **Provide opportunities for children to engage in increasingly complex activities, as they master prerequisite basic skills.**

2. Consultation with the child's IEP/IFSP members (e.g. parents and specialists).

- **Identify individualized objectives for children with special needs.**
- **Determine/learn specialized "interventions" needed to help children to meet specialized objectives, including procedures for monitoring children's progress.**
- **Get written suggestions on times/activities for implementing specialized "interventions" within your classroom environment/schedule.**

- Get a written list of activities that a child should not participate in (if any), because of physical or health risks.

- Develop written emergency procedures, if needed.

3 Personal creativity.

- Develop a procedure for record-keeping that matches your organizational needs - include information on: consultations with parents and IEP/IFSP team members, list of long-term and short-term objectives, specialized procedures, time lines for implementation and monitoring, individual activity plans, and written records of monitoring/assessment activities.

- Continue to expand your reservoir of activities that assist children with disabilities to be active participants in regular, age-appropriate, early-childhood activities.

Helpful Teaching Strategies

Incidental Teaching: Incidental teaching, is teaching during natural, everyday, activities. The process involves reinforcing a child's desirable behavior, to increase the likelihood of the behavior being repeated. Incidental teaching is a natural part of a nurturing adult/child relationship, occurring naturally in situations when children are learning basic skills of daily living such as walking, making a request, or pouring a glass of milk. Many of these activities will be self-initiated by the child.

By using verbal, physical or modeling prompts, adults can also help children to extend the skill level of current behavior, or demonstrate a desired new behavior, and then provide reinforcement to the child for carrying out the behavior. For example, if a child can pour their own glass of milk, incidental teaching might involve helping the child learn to fill the family's beverage glasses during dinner. For incidental teaching to be effective: a) the learning situation should be in a place where the child is familiar with the daily environment or routine, and b) should be practiced over an extended period of time, without pressuring the child, until the desired behavior is self-initiated on a routine basis.

Coincidental Teaching: Coincidental teaching is similar to incidental teaching, in that the teaching occurs during normal daily activities, and involves reinforcement. The basic difference is that, while incidental teaching is carried out within particular daily activities, coincidental teaching involves planning a variety of learning opportunities across situations or contexts. In coincidental teaching, the process is as follows: 1) decide on the skill you want the child to learn, 2) think of a variety of situations that occur during the day that could provide an opportunity to teach the skill, 3) arrange for the teaching opportunities to occur, 4) prompt the child to perform the skill, and 5) provide reenforcement.

A frequent example of coincidental teaching is the process of teaching a child to say please and thank you. Once the decision has been made to teach the skill, each time a child makes a request, an adult prompts the child for saying please or thank you, and then provides reinforcement through filling the child's request, and providing praise to the child for saying thank you.

Task Analysis: The process of task analysis involves taking a complex task and breaking it down into small steps, which can be mastered in succession, until the complex task can be performed in its entirety. New skills are generally easier for any of us to learn if learning can occur in small sequential steps. For adults, learning to drive a car provides a good example of applied task analysis. First, we learn how to adjust the seat, mirrors, etc.. Then we learn how the turn signals, clutch, breaks and gear shift work. Next we learn how to turn on the car and drive both forward and reverse, and make turns (this often occurs in the safety of a parking lot). Once we have learned to maneuver the car, we are taken on back roads, slowly progressing to city streets, and finally to multiple lane highways.

We would never expect to be able to hand the keys to a car to someone who has never driven before, and expect them to go right out and drive on an eight lane highway. Task analysis is a useful way for adults to think about tasks we want children to learn, in order to provide a learning sequence that will encourage success rather than failure for children.

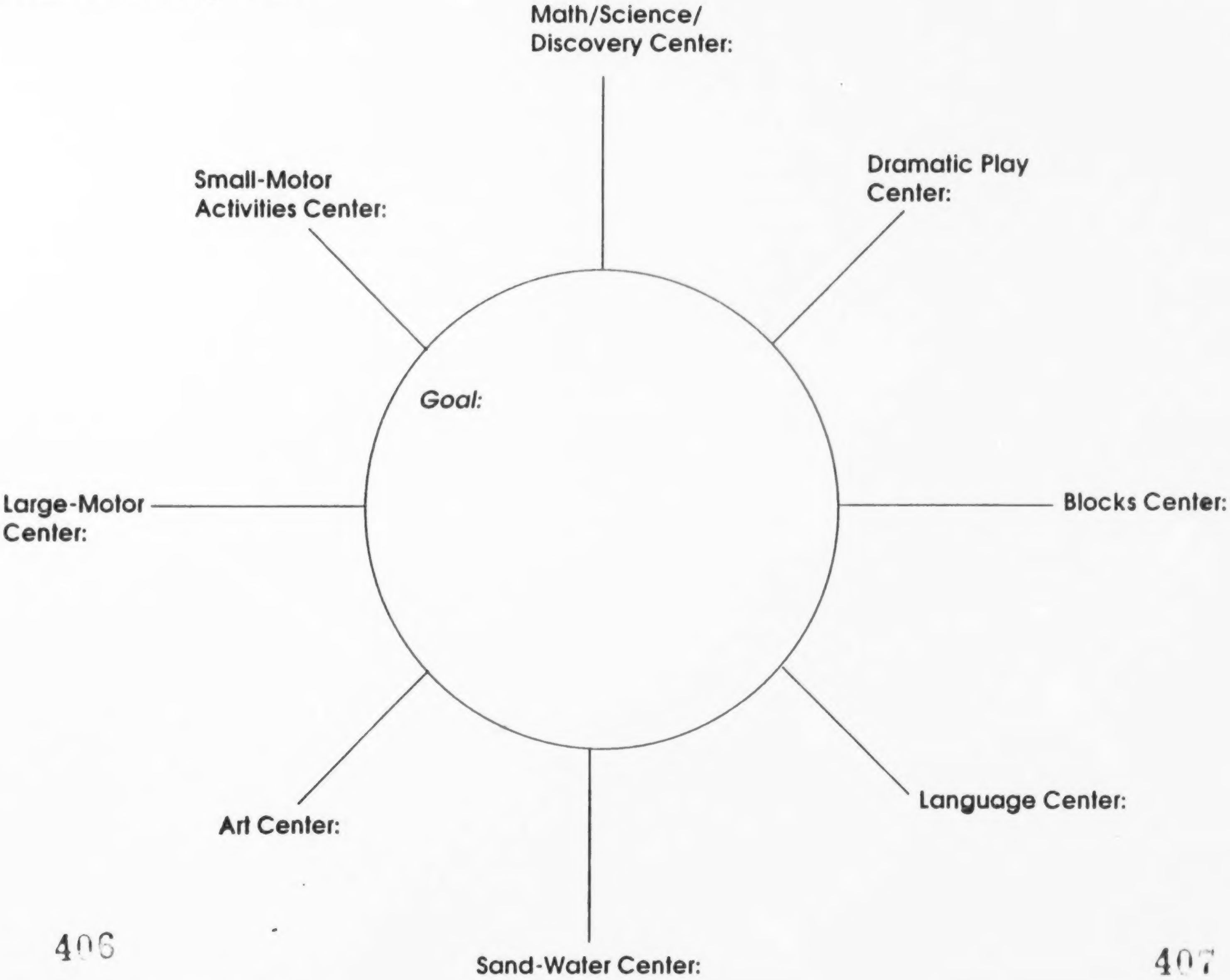
Teaching Social Skills: Incidental teaching, coincidental teaching, and task analysis can be used to help children learn social skills as well as concrete tasks. Social skills such as sharing, helping, and playing together are abstract, rather than concrete behaviors. If we observe people performing these skills, however, we can begin to see patterns of concrete behaviors that make up the complex social skill.

For example, the social skill of helping generally involves the following sequence: 1) person A observes that person B may need help; 2) person A asks person B if they need help; 3) person B responds "yes" or "no"; 3) person A asks how they can be of help to person B; 4) person B communicates to person A how they can help; 5) person A helps person B as indicated. To teach the social skill of helping, a variety of every day activities can be identified where helping would occur naturally so that the process of incidental teaching can occur. Examples of a mealtime scenario which could involve incidental teaching might include passing the dishes of food during dinner, helping a baby sister eat her strained carrots, and helping Dad to wash the dishes after dinner. Additional periods of the day can be identified which could be used to apply coincidental teaching strategy to the skill of helping. In addition, each step of the sequence could be discussed within a small group of children, perhaps using a children's story to highlight the main points. Extended learning activities could involve having children draw pictures of helping behaviors etc.

Children who have mastered particular social skills can also be trained as peer tutors to assist other children to learn the skills. The basic steps for training peer tutors involve: 1) talking to the potential peer tutor about the idea of being a peer helper; 2) asking the child if they are interested in learning how to become a peer helper; 3) role playing the process of a peer helper helping another child to learn a skill; 4) observing the peer helper helping another child; 5) talking about the experience with the peer helper and giving guidance; and 6) gradually reducing supervision during the peer helping process, maintaining periodic observations and discussions as needed.

Source: Adapted from Poster Series, Exceptional Child Center, Outreach and Development Division, Utah State University, Logan, Utah.

Center Activity Plan


Math/Science/
Discovery Center:
Small-Motor
Activities Center:
Dramatic Play
Center:
Goal:
Large-Motor
Center:
Blocks Center:
Art Center:
Language Center:
Sand-Water Center:

Center Activity Plan

Goal:

Action Steps:

A. Math/Science/Discovery Center:

B. Dramatic Play Center:

C. Blocks Center

D. Language Center

E. Sand-Water Center:

Environment/Therapy Integration Form

Child's Name: ____________________
Date: ____________________

Physical Therapy: ____________________
Speech-Language Therapy: ____________________
Occupational Therapy: ____________________
Other: ____________________
____
____

Objectives/Skills	Daily Routine/Activities			

Comments/Suggestions:

Notify Therapist if any changes in
objectives need to occur.

Therapist: ____________________
Phone # : ____________________

(Source: Growing Together Preschool, Lexington KY)

Environment/Therapy Integration Form

Child's Name:
Date: May, 1990

Physical Therapy: ✓
Speech-Language Therapy:
Occupational Therapy:
Other:

	Daily Routine/Activities			
Objectives/Skills	**Play on Floor**	**Play At Table**	**Bath/Diapering**	**Outside**
Increase Strength	Wheelbarrow with support at pelvis.	1/2 kneel position - play with puzzle on table	Have child kick legs Reach with legs for object overhead	Crab Walk Walk on Toes Walk Backwards on Heels
Increase Trunk Rotation	Sidesitting Play With Puzzle Placed on Chair	Position Chair Sideways at Table		"Washing Machine" - Stand back-to-back and pass ball to child's right.

Comments/Suggestions: Sitting Positions - 1.) In small chair - feet on blocks Avoid "W" sitting
2.) In cubed chair
3.) At picnic table
4.) In rocking chair

Notify Therapist if any changes in objectives need to occur.

Therapist: Nancy [illegible] P.T.
Phone # :

(Source: Growing Together Preschool, Lexington KY)

Appendix N

Project Lexington Resource Directory

ASSESSMENT

Battelle Developmental Inventory Materials
DLM Teaching Resources
One DLM Park
Allen, TX 75002.

Description: These materials consist of a Screening Test Examiners Manual, Screening Tests, and Screening Tests Scoring Booklets. We have two copies of this.

Birth To Three Assessment and Intervention System
Teaching Resources
One DLM Park
Allen TX 75002

Description: These materials consist of an intervention manual which is a parent-teacher interaction program, screening tests of learning and language development examiners manual and a checklist of learning and language behavior examiners manual as well as screening test of learning and language development record form and checklist of learning and language behavior record form.

CAMS Early Intervention Program
Walker Book Corporation
720 5th Ave.
New York, NY

Description: This series consists of a training manual, receptive language program, expressive language program, self help program, motor program, social emotional program as well as including a motor program placement test answer sheet.

The Home Stretch Kaplan Press
P.O. Box 609
1310 Lewisville Clemmons Rd.
Lewisville, NC 27023.
919-766-7374.

Description: This is a kit that can be used as an adjunct to "A Planning Guide to the Preschool Curriculum", or by itself as a home activities guide to encourage parents to follow through with unit topics at home and increase the child's awareness of the concepts. The activities cover varied needs of the growing child. It uses items commonly found in most homes.

Home Stretch Kits
Kaplan School Supply
P.O. Box 609
Lewisville, NC 27023
1-800-334-201

Description: These are the materials necessary for use with the Home Stretch. 2.
Description: This is an entire kit of LAP file books as well as all the materials necessary for early LAP screening.

The Mattel Developmental Inventory
DLM
One DLM Park
Allen, TX 75002

Description: This set consists of the Mattel Developmental Inventory Examiners Manual, Inventory Cognitive Domain, Inventory Communicative Domain, Inventory Screening Test, Inventory Personal Social Domain, Adaptive Domain, Motor Domain, Screening Test Scores and Booklets.

Mattel Developmental Inventory Supplemental Materials, Test Administration Kit
DLM
One DLM Park
Allen, TX 75002

Description: These are the necessary materials to administer the Mattel Developmental Inventory.

LAP Revised Kit.
Kaplan Press
P.O. Box 609
1310 Lewisville Clemmons Road
Lewisville N.C. 27023

Description: Contains material and instructional guides.

Learning Activities For The Young Child
Kaplan Press
P.O. Box 609
1310 Lewisville Clemmons Road
Lewisville N.C. 27023

Description: Cards of activities for children age 36 thru 72 months.

LAP Kindergarten Screen
Kaplan Press
P.O. Box 609
1310 Lewisville Clemmons Road
Lewisville N.C. 27023

Description: Complete diagnostic kit for entering kindergarten children.

Hawaii Early Learning Profile
VORT Corporation
Palo Alto, CA 94306

Description: This kit contains the following books:
Parents Helper
Help When The Parent Is Handicapped
Help For Special Preschools
Help At Home
Classroom Aids Helper
Help Activity Guide and Help For Parents Of Children With Special Needs
*Parts of this kit can also be checked out individually.

DIAL-R (Developmental Indicators for the Assessment of Learning - Revised)
AGS
Circle Pines, Minnesota 55014-1796

Description: This kit contains booklets and kits for concepts areas, motor area and language area assessment.

Family Day Care Rating Scale
Teachers College Press
Columbia University
1234 Amsterdam Ave.
New York, NY 10027

Description: Contains rationale as well as a rating scale items and notes for clarification.

Early Childhood Environment Rating Scale
Teachers College Press
1234 Amsterdam Ave.
New York, NY 10027.

Description: Contains rating scale items and notes for clarification.

Infant Toddler Environment Rating Scale
Teachers College Press
1234 Amsterdam Ave.
New York, NY 10027

Description: Contains rating scale items and notes for clarification. Three copies.

System To Plan Early Childhood Services

Description: This set contains administration manual, developmental specs, program specs, and team specs.

Communication and Infancy - Assessment and Intervention
Early Intervention Team Training Project
Interdisciplinary Human Development Institute
Affiliated Programs in Kentucky.

Description: This is a booklet and a video dealing with assessment.

Observing Development of The Young Child
Merrill - A Division of MacMillan Publishing Co
New York.

Description: A system for observing and recording the development of young children ages two to six in an early childhood classroom setting.

Assessing Infants and Preschoolers With Handicaps
Merrill Publishing Company
A Bell and Howell Information Co.
Columbus, Toronto, London, Melbourne

Description: This book addresses fundamental and specialized issues of assessment and discusses assessment within the context of key curriculum developmental domains.

BOOKS

Developing Sign Communication with the Multiply Handicapped Sensory Impaired Child
Ski Hi Institute
Dept. of Communicative Disorders
Utah State University
Logan, Utah

Description: This book contains examples of primitive signing, corrective signing, interactive signing designed primarily for parents who are helping their young multiply handicapped physically impaired children to go to primitive, corrective signing schools.

Developing Cognition in Young Children
SKI-HI Outreach
Utah State University
Logan, Utah

Description: This is a book which contains cognition program lesson plan and goal directed play activities for young hearing impaired children.

Developing Sign Communication with the Multi-Handicapped Sensory Impaired Child.
SKI-HI Institute
Utah State University
Logan, Utah

Description: Developing Cognition In Young Hearing Impaired Children.

Communication and Sign Language. A Series of Lessons for Beginning Signers.
Hope, Inc.
Printed in U.S.A. by Downs Printing,
Hiram, Utah 84319.

Description: This book is a series of lessons aimed at the beginner teaching them how to learn basic sign language.

Planning Guide for Gifted Preschoolers
Chapman Press
P.O. Box 5128
Winston Salem, N.C. 27113-5128.

Description: This is curriculum developed with gifted handicapped children.

Before the Basics by Beth Voss.
Turn The Page Press
203 Baldwin Street
Roseville, CA 95678.

Description: This book contains a checklist for appropriate activities for children as well as suggestions and resources for preschool children.

Movement Education. A Program for Young Children ages 2 to 7.
Murro Drake Educational Associates
79 Mellwood Drive
Newport News, VA. 23602
804-877-1172

Description: This book is designed for any parent or teacher of young children. It offers assessment techniques, curriculum ideas and short ways for adults to help children build self confidence and body awareness.

Anti-biased Curriculum
National Association for the Education of Young Children
1834 Connecticut Ave., N.W.
Washington, D.C. 20009-5786

Description: The focus of this book is tools for empowering young children. It includes choosing an anti-biased curriculum as well as creating an anti-biased environment in integrating these two processes into a preschool classroom.

Learning Letters Through All Five Senses
Griffin House 3706 Otis Street
Mt. Rainier, Maryland 20712.

Description: This book is a multisensory approach to learning the alphabet.

Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth Through Eight
National Association for The Education of Young Children
1834 Connecticut Ave., N.W.
Washington, D.C. 20009-5786

Description: This book contains examples of appropriate and inappropriate practices broken down from ages birth through eight.

Caring For Preschool Children Vol. I.
Teaching Strategies, Inc.
P.O. Box 42243
Washington, D.C. 20015.

Description: This is a training program designed to help teachers acquire the skills and knowledge needed to provide quality care for preschool children.

Caring For Preschool Children, Vol. II
Teaching Strategies, Inc.
P.O. Box 42243
Washington, D.C. 20015

Description: This is a continuation of the earlier training program.

Planning Guide for Gifted Preschoolers
Chapman Press
P.O. Box 5128
Winston Salem, N.C. 27113-5128

Description: This is curriculum developed with gifted handicapped children. There are two copies.

I Can Do It. I Can Do It
Griffin House, Inc.
3706 Otis Street
Mt. Ranier, MD 20712

Description: This is 135 successful independent learning activities.

Educational Home Model Project
Montana University Affiliated Program at the University of Montana

Description: This is a series of booklets which consist of - A Blueprint for Play, Arranging the Environment for Young Children with Handicaps, A Great Place To Be Me, Selecting a Child Care Program When Your Child Has A Handicap, Handling and Positioning Children With Motor Impairments, Needing a Challenge, A Skill Checklist for Providers of Integrated Day Care, The Childhood Checklist, Making Day Care Programs Accessible for Young Children, Little Boys and Band Aids, A Health and Safety Handbook for Day Care Providers, and Being Part of A Team - Community Coordination.

Promoting Posture and Movement Skills
Interdisciplinary Human Development Institute
University of Kentucky.

Description: This is a trainer's manual for developing skills in infancy.

Nutrition in Handicapped Children
Florida International University
State of Florida Dept. of Education
Tallahassee, FL.

Description: A Handbook for Parents and Teachers.

Early Intervention for Handicapped And At Risk Children
Love Publishing Company

Description: An introduction to early childhood special education.

Adapting Early Childhood Curricula for Children With Special Needs
Merrill Publishing Co.
A Bell and Howell Information Co.
Columbus, Toronto, London, Melbourne.

Description: A comprehensive coverage of the educational needs of young handicapped children.

Developmental Profile
Delmar Publishers
Two Computer Dr. West
Box 15-015
Albany, NY 12212.

Description: Contains a brief comprehensive guide to the development of young children from birth to six. Includes developmental checklists for each age.

Parent Information Packet
The Spina Bifida Association of Kentucky
Kosair Charity Center
982 Eastern Parkway
Louisville, KY 40217

Description: Provides basic information about Spina Bifida and about services available in Kentucky for persons with Spina Bifida.

Writing and Implementing An IEP
Fearon Education
Belmont, CA.

Description: A step by step plan to write and implement IEP's.

Mainstreaming Ideas for Teaching Young Children
National Association for Education of Young Children
Washington, D.C.

Description: This book contains ideas for mainstreaming young children.

Topics in Early Childhood Special Education
Pro-Ed
8700 Shoal Creek Boulevard
Austin, TX 78758-6897

Description: This book is a collection of articles on mainstreaming.

Article #1 - Major Accomplishments and Future Directions in Early Childhood Mainstreaming.

Article #2 - The Unfulfilled Promise of Integration: Does Part H Ensure Different Rights and Results Than Part B of the Education of the Handicapped Act?

Article #3 - Normalizing Early Intervention.

Article #4 - Mainstreaming at the Preschool Level: Potential Barriers and Tasks for the Field.

Article #5 - Providing Early Intervention Services In Integrated Environments: Challenges and Opportunities for the Future.

Article #6 - Criterion of the Next Environment and Best Practices: Mainstreaming and Integration 10 Years Later.

Article #7 - Promoting a Normalizing Approach to Families Integrating Theory with Practice.

Article #8 - The Relationship Between Time In Integrated Environments and Developmental Gains in Young Children with Special Needs.

Effective Teaching Principles and Procedures of Applied Behavior Analysis with Exceptional Students
Allyn and Bacon, Inc.
160 Gould Street
Needham, Massachusetts 02194-2310

Description: An introduction to applied behavior analysis as it relates to teaching and managing the behavior of students with handicaps.

More Homemade Battery Devices for Severely Handicapped Children with Suggested Activities
Linda Burkhart
8503 Rhode Island Ave.
College Park, MD 20740

Description: This book describes a variety of adapted switches that can be easily made at home by persons working with severely handicapped children. The book also provides various activities to go with the switches/devices.

Homemade Battery Powered Toys and Educational Devices for Severely Handicapped Children
Linda Burke
8503 Rhode Island Ave.
College Park, MD 20740

Description: This book describes how to make and use simple switches that can be activated by a severely handicapped child, so that the child can better explore, manipulate and play in their world.

Charlotte Circle Curriculum Guide: Social Reciprocity Interventions for Infants and Young Children with Severe Handicaps and their Families.
Department of Teaching Specialties
The University of North Carolina at Charlotte
Charlotte, North Carolina 28223

Description: A supplementary curriculum guide which can be used by parents or teachers as part of an early intervention program for those children 0-3. The emphasis is to support the relationship between parents and their children.

Federation For Children With Special Needs
95 Berkeley Street, Suite 104
Boston, MA 02116

Description: This is a 7 volume series of issues of parents of children with special needs.

(1) Purposeful Integration ... Inherently Equal.
(2) Preparing for Life: A Manual for Parents on the Least Restrictive Environment.
(3) Why Is My Child Hurting? Positive Approaches to Dealing with Difficult Behavior.
(4) After School ... Then What? The Transition to Adulthood.
(5) Roots and Wings: A Manual About Self-Advocacy.
(6) Health Care Issues for Children with Special Health Needs and Disabilities.
(7) Teaching Social Skills to Youngsters with Disabilities.

Rebuilding Your Dream: Family Life with a Disabled Child
University of Iowa Publications Department
Campus Stores, M 105 OH
University of Iowa
Iowa City, Iowa 52242

Description: This book addresses common issues or problems that occur in family life with a disabled child, and suggestions for what can be done about them.

CURRICULUM

The Creative Curriculum for Early Childhood Video and A Guide for Supervisors and Trainers on Implementing the Creative Curriculum for Early Childhood
Teaching Strategies, Inc.
6507 32nd St., N.W.
Washington, D.C. 20015

Description: This program is broken into three parts. One deals specifically with introducing the curriculum, the other on working with staff in areas like self motivation, verification of feedback and classroom visits which deals with such areas as environment, equipment and materials program structure activity to use in experiences and prepare parental involvement.

The Carolina Curriculum for Preschoolers With Special Needs
Paul H. Brookes Publishing Company
P.O. Box 10624
Baltimore, MD 21285-0624.

Description: Contains assessment and sample curriculum sequences for integrated preschool.

The Carolina Curriculum for Handicapped Infants and Infants At Risk
Paul H. Brookes Publishing Co.
P.O. Box 10624
Baltimore, MD 21285-0624

Description: Contains assessment and sample curriculum sequences for integrated preschool.

Carolina Curriculum Kit
Kaplan Press
P.O. Box 609
1310 Lewisville Clemmons Road
Lewisville, N.C. 27023

Description: The materials necessary for use in the Carolina Curriculum.

Early Learning Activity Cards
Kaplan Press
P.O. Box 609
1310 Lewisville Clemmons Road
Lewisville, N.C. 27023

Description: Activities designed for use with the early LAP developmental assessment.

The Preschool Letters and Notes to Parents Book
Griffin House
Mt. Ranier, MD.

Description: Successful notes, ledgers, forms used by schools and day care centers used to communicate with parents.

Partners for Learning
First Teacher Press
First Teacher, Inc.
Bridgeport, CT

Description: Promoting Parent Involvement in Schools.

Getting Involved. Workshops for Parents
Highscope Press
600 N. River St.
Ypsilanti, MI 48197

Description: This workshop is aimed at helping parents to get more involved in their children's learning.

Partners For Learning
Kaplan Press
P.O. Box 609
1310 Lewisville Clemmons Road
Lewisville, N.C. 27023

Description: Comprehensive program including materials for both child curriculum and staff development. Can be used by teachers and parents to promote development in the following areas:

cognitive and fine motor skills, social and self-development, gross motor, and language. Provides step by step instruction for each activity.

SKI HI Home Intervention Program Adaptation
SKI HI
Logan Utah

Description: A Home Visit Curriculum.

The Creative Curriculum
Teaching Strategies
P.O. Box 42243
Washington, D.C. 20015

Description: Enhancing the child's learning through play by providing an interesting and stimulating environment. Explains the purpose and benefits of various learning centers.

House Pals
Mattel Corp.
Hong Kong

Description: These are dolls with various disabilities. These are manufactured by Mattel Corp. in Hong Kong. We have the following dolls:

1. *Ski instructor (one leg) (2)*
2. *Ballerina Dolls (hearing impaired) (2)*
3. *Sports Dolls (blind, w/dog) (2)*

PANDA - Preventing the Abuse of Tobacco, Narcotics, Drugs and Alcohol. Chapel Hill Training Outreach Project.

Description: This is Collection of audio tapes, stories, pictures to color, and activities for children which address the issues of tobacco, drugs, and alcohol.

Instant Training Guide
Kaplan Press
P.O. Box 609
1310 Lewisville Clemmons Road
Lewisville, N.C. 27023

Description: This is a packet of lectures, discussion questions and activities on the topic of accepting handicapping conditions.

VIDEO

Children With Special Needs
Young Adult Institute
460 W. 34th St.
New York, NY 10001
Phone: 212-563-7475

Description: These are a series of 36 tapes and instructor's guide dealing with children with special needs.

Tape #1 - Parent Support Groups
Tape #2 - Managing Your Child's Behavior - Part I
Tape #3 - Managing Your Child's Behavior - Part II
Tape #4 - Stress and Coping
Tape #5 - Preventing Sexual Abuse
Tape #6 - Planning Your Child's Future
Tape #7 - Parent - Professional Cooperation
Tape #8 - The Team Approach
Tape #9 - The Role of the Clergy
Tape #10 - The Role of the Doctor
Tape #11 - Custody in Divorced Families
Tape #12 - Families with Multiple Problems
Tape #13 - Issues of Family Life - Part I
Tape #14 - Issues of Family Life - Part II
Tape #15 - Fathers
Tape #16 - Siblings
Tape #17 - Having A Disabled Brother or Sister
Tape #18 - Extended Family Members
Tape #19 - Working With Your Child At Home
Tape #20 - Motor Development
Tape #21 - Language Development
Tape #22 - Emotional Development
Tape #23 - Cognitive Development
Tape #24 - Early Intervention
Tape #25 - Transition In The School
Tape #26 - Parents And Teachers In Partnership
Tape #27 - Public Law 94-142
Tape #28 - Public Law #94-142 Part II
Tape #29 - Your Public Schools
Tape #30 - School Integration
Tape #31 - Having A Baby in the NICU
Tape #32 - Infant Temperament

Tape #33 - Having a Developmentally Disabled Child
Tape #34 - Causes and Preventions
Tape #35 - Diagnosis
Tape #36 - Community Integration

Hearing Aid Monitoring
Ladnar Productions
P.O. Box 852
Logan, Utah 84041

Description: This is a videotape which comes with a list and check procedure for ear level hearing aid.

Listening Environments
Ladnar Productions
P.O. Box Box 852
Logan, Utah 84041

Description: This is a videotape which comes with a list and check procedure ear level hearing aid.

SKI HI Total Communication Videotape Programs
SKI HI Institute
Department of Communicative Disorders
Utah State University
Logan, Utah

Description: This is a series of 20 videotapes dealing with different areas of life for the hearing impaired.

Tape #1 - The Family

Lesson 1 - Identifying Members Of The Family
Lesson 2 - Getting Along With The Family or Family Survival
Lesson 3 - More Family Survival Signs

Tape #2 - Morning Routines

Lesson 4 - Getting Up
Lesson 5 - Getting Dressed
Lesson 6 - Brushing Teeth and Combing Hair

Tape #3 - Daily Routines

Lesson 7 - Changing Diapers
Lesson 8 - Getting a Drink
Lesson 9 - Going To The Bathroom

Tape #4 - Evening Routines

Lesson 10 - Getting Dressed For Bed
Lesson 11 - Story Time - Introduction to Animals
Lesson 12 - Little Rhymes, Songs and Prayers

Tape #5 - Mealtimes and Snacks

Lesson 13 - Foods
Lesson 14 - More Foods and Eating Meals
Lesson 15 - Preparing Meals.

Tape #6 - The Body and Feelings

Lesson 16 - Body Parts
Lesson 17 - Getting Hurt & Being Sick
Lesson 18 - Expressing Feelings

Tape #7 - Living and Working in the Home

Lesson 19 - Things in the House and Doing Housework
Lesson 20 - Taking Care of Clothes
Lesson 21 - Setting, Clearing Table and Doing Dishes

Tape #8 - Playing and Doing

Lesson 22 - Toys and Playthings
Lesson 23 - Playing Outside the House
Lesson 24 - Playing Inside the House, i.e. Coloring, Counting, etc.

Tape #9 - Going Somewhere

Lesson 25 - Traveling
Lesson 26 - Visiting Places
Lesson 27 - Going to School

Tape #10 - Putting It All Together

Lesson 28 - Manual Alphabet
Lesson 29 - Question Words and Connecting Words
Lesson 30 - Prepositions and Affixes

Tape #11 - People

Lesson 31 - Relatives and Relationships
Lesson 32 - Identifiers and Pronouns
Lesson 33 - People in the Community

Tape #12 - The Body and Clothing

Lesson 34 - Body Parts
Lesson 35 - Sickness and Injury
Lesson 36 - Clothing

Tape #13 - Animals

Lesson 37 - Home and Farm Animals
Lesson 38 - Wild Animals
Lesson 39 - Birds, Fish, Insects and Reptiles

Tape #14 - Food

Lesson 40 - Fruits and Vegetables
Lesson 41 - Fruits and Beverages
Lesson 42 - Meats, Main Dishes and Cooking Ingredients

Tape #15 - Describing and Feeling

Lesson 43 - Describing People, Things, Objects
Lesson 44 - Describing Sizes, Amounts, Distances and Actions
Lesson 45 - Ways of Feeling

Tape #16 - Inside and Outside The House

Lesson 46 - Things In The House
Lesson 47 - Things In the Yard
Lesson 48 - Nature

Tape #17 - Time and When Things Happen

Lesson 49 - Days and Time
Lesson 50 - Months and Seasons
Lesson 51 - Holidays and Celebrations

Tape #18 - Action in Doing Things

Lesson 52 - Communication and Action Words
Lesson 53 - Action Words Continued
Lesson 54 - Less Active Words

Tape #19 - Going Places

Lesson 55 - Getting There
Lesson 56 - Transportation and Directions
Lesson 57 - Countries

Tape #20 - Going to School

Lesson 58 - At The School
Lesson 59 - Subjects - Reading, Writing and Arithmetic and Communications
Lesson 60 - Subjects - Music, Science, Art and Sports

Description: This series comes with the SKI HI Home Total Communication Video Tape Program Instruction Booklet and Guidelines for Video Store Participation In the SKI HI Home Total Communication Video Program.

SKI HI Total Communication and Video Tape Program
Utah State University
Logan, Utah

Description: These are sign activity and reference booklets made to accompany the SKI HI total communication videotapes.

Best Start - Project Bridge

Description: This video describes an interdisciplinary team design making process.

Project Enlightenment - First Years Together

Description: Describes a developmental evaluation of a child and how the parents are taught and supported through the process.

Bringing Out the Best Participants' Workbook
Research Press
2612 N. Mattis Ave.
Champaign, IL 61821.
217-352-3273

Description: Both the participants' workbook and the video deal with encouraging expressive communication in children with multiple handicaps.

Introduction to The Early Childhood Environment Rating Scale
Teachers College Press
Columbia University

Description: This set includes an instructor's guide, a film cassette and a video.

Chapel Hill Public Law 99-457
Chapel Hill, NC.

Description: Video which comes with information sheet.

Talking to Babies
Division of Special Education
5151 State University Drive
Los Angeles, CA 90032

Description: Mother-Infant Communication Project.

Talking to Toddlers
Division of Special Education
5151 State University Drive
Los Angeles CA 90032

Description: Mother-Infant Communication Project.

Young and Special
Electro Systems, Inc.
5400 Walshire Dr.
Columbus, OH 43232
614-863-5522

Description: This is a 30 volume video series dealing with mainstreaming and early intervention in the preschool classrooms. These video tapes come with a leader's guide and student material. The titles are
Vol. 1 Not In My Class;
Vol. 2 Why Can't We Wait Until They're Older
Vol. 3 How Will I Explain It To The Other Children
Vol. 4 What Do I Tell The Parents
Vol. 5 Demystifying Special Education
Vol. 6 I Worry About Behavior Management
Vol. 7 People Who Can Help
Vol. 8 Can you Really Test Them At That Age
Vol. 9 How Can You Tell What They Need?;
Vol. 10 Reflexes to Voluntary
Vol. 11 But What If She Can't Walk
Vol. 12 Position Is Everything in Life
Vol. 13 Reach, Grasp and Release
Vol. 14 When The Eye Is Quicker Than the Hand
Vol. 15 Like All The Other Kids
Vol. 16 Early Thoughts
Vol.17 I Teach Him But He Doesn't Learn
Vol. 18 Learning to Learn
Vol. 19 Why Would Being Bright Be A Problem
Vol. 20 Speaking Louder Than Words
Vol. 21. When Silence Isn't Golden
Vol. 22 How Can I Get Her To Talk
Vol. 23 You'll Never Believe What She Heard
Vol. 24 Watch Me Explain
Vol. 25 Believing Without Seeing
Vol. 26 Teaching Children To See
Vol. 27 Lets Not Even Talk About It
Vol. 28 Just A Feeling I Have
Vol. 29 In A Different World
Vol. 30 Love Always Helps

SKI HI Video of Five Slide Programs
Utah State University
Logan, Utah

Description: Home Hearing Aid
Home Communication
Home Auditory
Aural-Oral
Total Communication

Gifts of Love
National Downs Syndrome Society.

Description: Case studies of four families with a down syndrome child. Some general information on down syndrome is given.

Parent to Parent National Training Package - Tape #1

Description: Program 1-6. How to set up a system of support for parents of children with special needs.

Parent to Parent National Training Package - Tape #2

Description: Program 7-11. Continuation of how to set up a support system for parents of children with special needs.

Looking At Young Children
Teachers College Press
Columbia University
New York and London

Description: This is a video as well as a book entitled "The Classroom Observer Developing Observation Skills In Early Childhood Settings.

Getting Started Together
Meyer Rehabilitation Institute
University of Nebraska Medical Center

Description: This is a 10 Volume series of continuing education self-instructional models.

Vol. 1	*Developmental Assessment Strategy*
Vol. 2	*Developmental Screening in the 0-3 Population*
Vol. 3	*Observing Infant Sensory Motor Development*
Vol. 4	*Intervention Strategies for Infants and Toddlers*
Vol. 5	*Developmental Intervention in The Neonatal Intensive Care Unit.*
Vol. 6	*Parent-Child Interaction*
Vol. 7	*Family Mediated Intervention*
Vol. 8	*Interpreting Difficult To Read Cues in The Disabled Infant*
Vol. 9	*Developing An Interdisciplinary Team*
Vol. 10	*Case Management*